

H-400 68-3501 BALTIMORE CITY HEALTH DEPARTMENT  
 J-525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-3501

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Jane Peters Hall JOHNSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 29, 1968 Hour 11:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year March 29, 1968 Hour 11:45 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 1-12-23		10. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Peters		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Elizabeth Pollet		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT Frederick Johnson 3709 Chesholm Rd.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-30-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-68	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1968		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Kelson Funeral Home		ADDRESS 1348 Calhoun St.	

MAILED

Wm. W. W.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520 68-3502				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3502	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
39				Jones, Nettie			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland			
				C. CITY OR TOWN Baltimore			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1961 Lexington Street			
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-4-89	
						9. AGE (In years lost birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Virginia		United States	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				Betty			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
no				226-50-8514		Mrs. Mary C. Floyd - Daug.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				old + new?			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				= myocardial infarction			
				Arteriosclerotic Cardio-Vascular			
				disease w/ atrial fibrillation			
				with occasional ectopic ventricular			
				systole; left ventricular			
				hypertrophy			
				Generalized Arteriosclerosis			
				Pulmonary Congestion			
				Pneumonia			
				Hemiparesis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4-20-1		II		Yes			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from March 21, 1968 to March 28, 1968, that (I) (we) last saw the deceased alive on March 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Assuncion L. Palafox				3-28-68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				1514 Division Street Balto. Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-31-68		Church Cemetery		Charlotteville, Va	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 1 1968		Robert E. Taylor		Kelson Funeral Home		1348 Calhoun St	

*[Faint, illegible handwriting covering the majority of the page, likely bleed-through from the reverse side.]*

Chas. E. Hays

5-421

68-3503 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3503

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BIRDINE SALISBURY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>3 26 68 9:20 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 26 1968 9:20 p.m.</b>	
6. SEX <b>Female</b>	7. RACE <b>Colored</b>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-5-09</b>	10. AGE (In years last birthday) <b>58</b>	E. STREET AND NUMBER <b>5 STOCKTON 1601</b> <b>1107 Stockton St.</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Lilly Porter</b>	
14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Gertrude Thompson same</b>	
19. <b>2230</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Subarachnoid Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bleeding Angioma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>223X</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Edward F. Wilson</b> M.D. EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 27, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-30-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>	25B. NAME OF REGISTRAR <b>A. J. F. Wilson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Kelson Funeral Home 1348 Calhoun St</b>	

5/7/68 - bleeding angioma of Brain - information  
from Med Exam - Dr. C. Wilson - via phone  
ge

S-322

68-3504

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3504

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLARENCE STOKES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>March 30, 1968</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 30, 1968 1:40 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL (DOA)</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		6. CITY OR TOWN <b>Baltimore</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-6-07</b>		10. AGE (In years lost birthday) <b>60</b>		E. STREET AND NUMBER <b>523 Pressman Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Simon Stokes</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Artha Washington</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>218050884</b>		18. INFORMANT ADDRESS <b>Mary Burrell 523 Presstman St.</b>	
19. <b>412.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-22-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>3-31-68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		24E. FUNERAL DIRECTOR ADDRESS <b>Nelson Funeral Home 1348 Calhoun St</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. J. J. J.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Nelson Funeral Home 1348 Calhoun St</b>	

WALTER POLK

OSKANA COUNTY

X

Paul H. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3505

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3505

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

RICHARD T. BAKER

2. DATE AND HOUR OF DEATH

3-27-68

4.45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

Balto 21216

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2309 Reslyn Ave.

5. SEX

M

6. RACE

C

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-27-93

9. AGE (In years last birthday)

75

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Baker

14. MOTHER'S MAIDEN NAME

Ella Dagg

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Bessie Smith 3657 Lauretta Ave.

18. 412.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

(B)

DUE TO, OR AS A CONSEQUENCE OF:

H. ASCVD

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

443X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-25-68 19 to 3-27-68 19 that (I) (we) last saw the deceased alive on 3-27-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Rafael

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

3-27-68

23C. PHYSICIAN'S NAME (Type)

E. RAFAEL

23D. ADDRESS

Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-30-68

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

(City, town, or county)

Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 1 1968

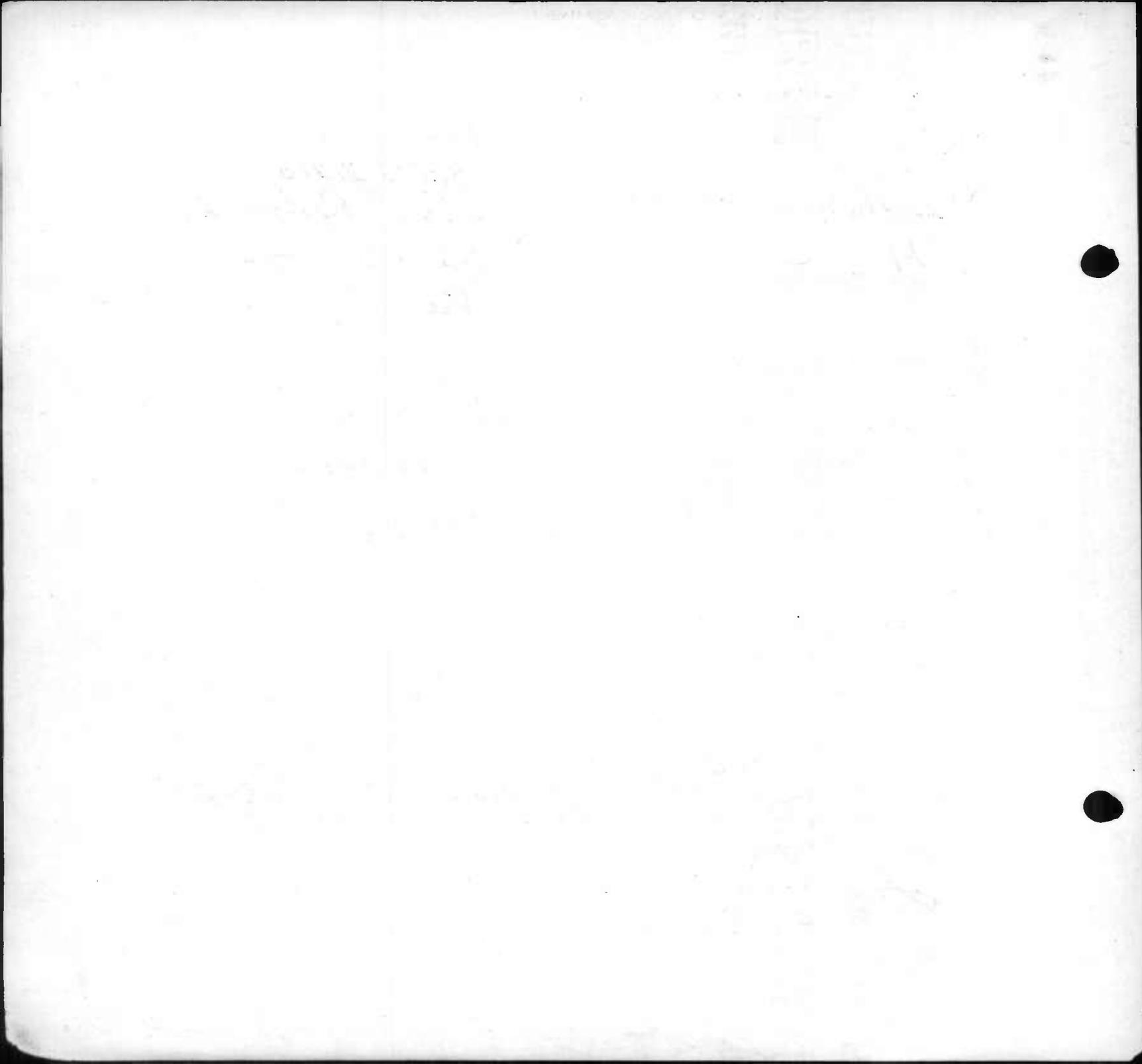
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Kilson Funeral Home 348 Calhoun St.

ADDRESS



1  
Wm-252

68- 3506 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3506

BIRTH NO. 64-12751

1. NAME OF DECEASED (Type or Print) MICAH DAMON <del>MICHAEL</del> MCGOWENS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 30, 1968 12:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR INSTITUTION) PROVIDENT HOSPITAL (DCA) 4/15/68		3. DATE PRONOUNCED DEAD Month Day Year Hour March 30, 1968 12:40 P.M.	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 5-13-64		10. AGE (In years lost birthday) 3 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1600 Spray Court 15-01
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Robert McGowens
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <del>Janet</del> Griffin, JEANNETTE LORETTA
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. none	18. INFORMANT ADDRESS Robert McGowens same
19. <u>E 814.7</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <u>E 812.4</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3 30 68 12:15 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Mount Street 142' ft. N. of Presstman St. 15-01		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Roland N. Kornblum</u> M.D. EXAMINER'S NAME (Type) Roland N. Kornblum, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 3-31-68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-68	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State) Arbutus Maryland		25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1968		25B. NAME OF REGISTRAR R. E. Tolson	

4/15/68 - Certificate of Live Birth for Micah Damon McGowens - #64-12751.

Mother's maiden name: Jeannette Loretta Griffin.

*LJC*

*Don McGowens*

## 68- 3507 CERTIFICATE OF DEATH

REG. NO.

68- 3507

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ELIZA TURNER

2. DATE AND HOUR OF DEATH

3/21/68

9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

42 Sinai Hosp of Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS

YES ☒NO ☐

E. STREET AND NUMBER

2202 Park Ave

5. SEX

Female

6. RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5/11/1896

9. AGE (In years  
last birthday)

71

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Private Family

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Lee Joneme

14. MOTHER'S MAIDEN NAME

Maggie

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

281-32-3948

17. INFORMANT

Mrs. Willie Mae Franklin - 2202 Park Ave

ADDRESS

18. 577.91

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

ASPIRATION PNEUMONIA

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 DAY

(B)

GEN. MALNUTRITION

DUE TO, OR AS A CONSEQUENCE OF:

1 YEAR

(C)

PANCREATIC INSUFFICIENCY

3 YRS

MEDICAL CERTIFICATION

587.2 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/7 1968 to 3/21 1968,  
that (I) (we) last saw the deceased alive on 3/21 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward R. Cohen MD

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3/21/68

23C. PHYSICIAN'S  
NAME (Type)

EDWARD R. COHEN

DEGREE

23D. ADDRESS

Sinai Hosp.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

3/26/68

24C. NAME OF CEMETERY OR CREMATORY

Crown Memorial Park

24D. LOCATION

Lanet

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT

APR 1 1968

25B. NAME OF REGISTRAR

Charles E. Finkbeiner

25C. FUNERAL DIRECTOR

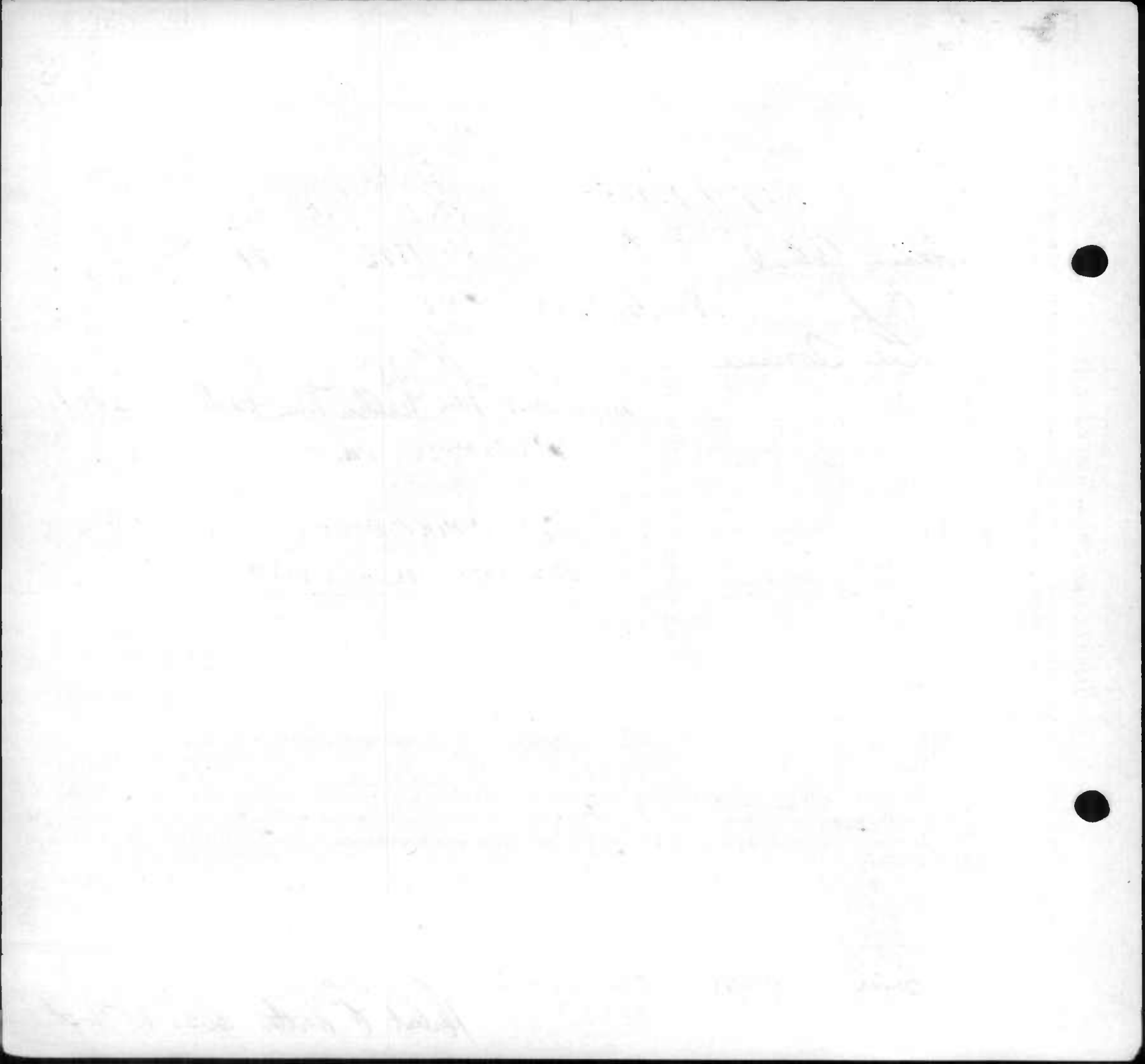
Herbert C. Nuttall

ADDRESS

3035 W. North Ave

FUNERAL DIRECTOR: IMPORTANT

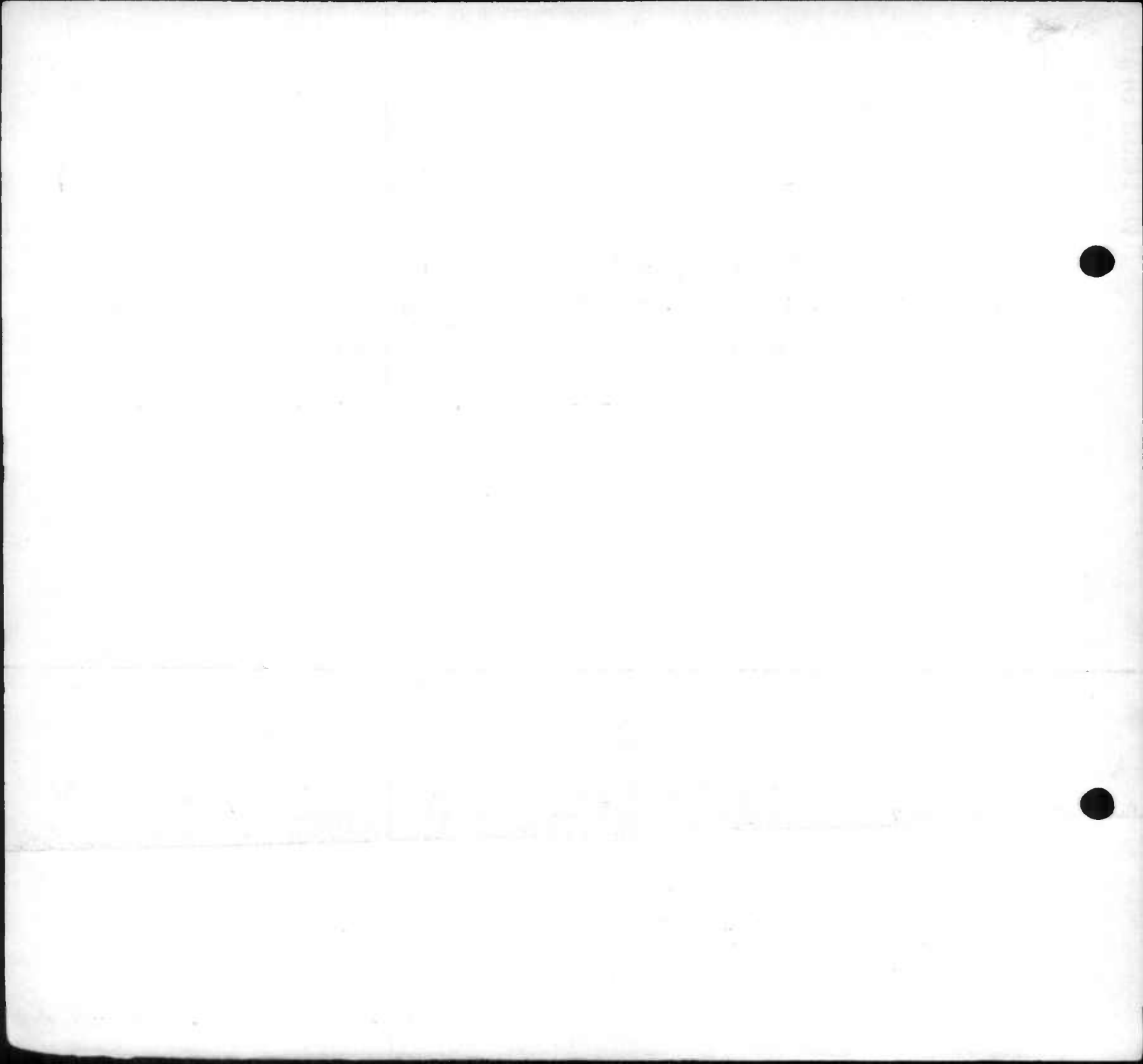
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6153		68-3508		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-3508	
BIRTH NO.		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Alan Edward Barnett				March 26, 1968 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  2929 Presbury Street				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write R.U.A. and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2929 Presbury Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days	
Male	Colored	Married		Jan 20, 1905	63		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Shipping Clerk		Jos. Zamoski Co		Jamaica, British West Indies		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Henry Arthur Barnett				Alice McQuinney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-01-4763		Mrs. Carmen Barnett 2929 Presbury Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO HYPERTENSIVE - CARDIO-VASCULAR DISEASE			
				(B) DUE TO ARTERIOSCLEROSIS			
				(C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
443X II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1/26 1968 to 3/26 1968, that (I) (we) lost saw the deceased alive on 3/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Gilbert L. Banfield						3/29/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Gilbert L. Banfield				722 N. Fulton Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/30/68		Mount Auburn Cemetery		Baltimore Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 1 1968		Robert E. Farley		Herbert E. Nutter 3035 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3509

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3509

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANN S. BUNTON

2. DATE AND HOUR OF DEATH

MAR. 28, 1968 1:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2426 ELLAMONT ST.  
BALTIMORE, M.D.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS

YES ☒ NO ☐

E. STREET AND NUMBER

2426 ELLAMONT ST.

5. SEX

F

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

8/31/21

9. AGE (In years last birthday)

47

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CLERK-TYPIST

10B. KIND OF BUSINESS OR INDUSTRY

U.S. GOV'T.

11. BIRTHPLACE (State or foreign country)

WASH, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LOUIS BUNTON

14. MOTHER'S MAIDEN NAME

VIOLA CLARK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

VIOLA C. BUNTON (MOTHER)

ADDRESS

SAME

18. 183.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC CARCINOMA OF OVARY

(B)

DUE TO, OR AS A CONSEQUENCE OF:

3 years

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

175.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

MAR. 1965

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

OVARIAN CARCINOMA

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from AUG 1967 to 3/27 1968, that (I) (we) last saw the deceased alive on 3/27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. W. STEWART

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

3/28/68

23C. PHYSICIAN'S NAME (Type)

D. W. STEWART, M.D.

23D. ADDRESS

3414 DUVALL AV. (21216)

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/1/68

24C. NAME OF CEMETERY OR CREMATORY

ARBUTUS MEMORIAL PARK

24D. LOCATION

ARBUTUS BALTO CO, MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

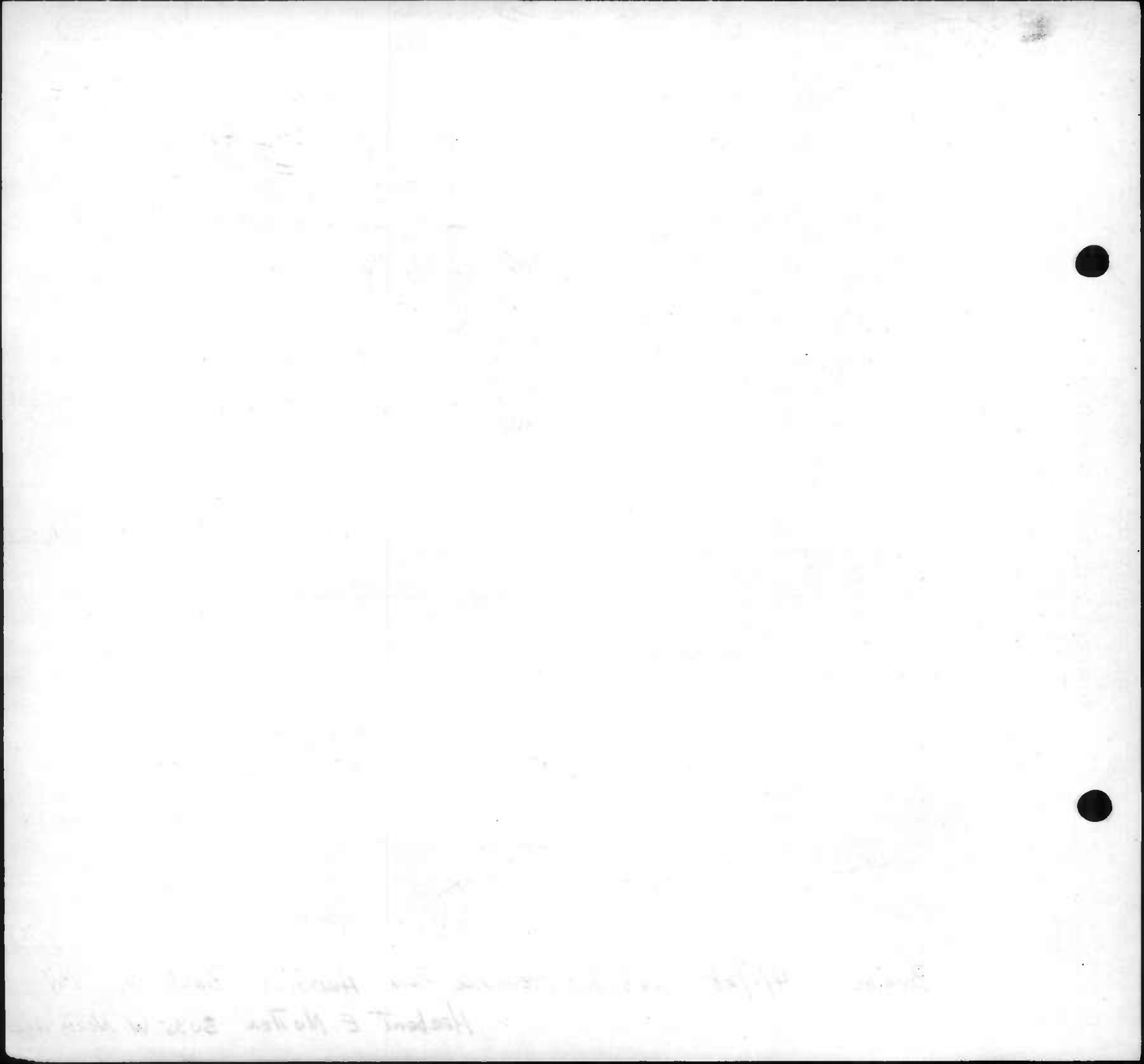
25C. FUNERAL DIRECTOR

ADDRESS

APR 1 1968

Robert E. Taylor

HERBERT E. NUTTER 3035 W. NORTH AVE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3510

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3510

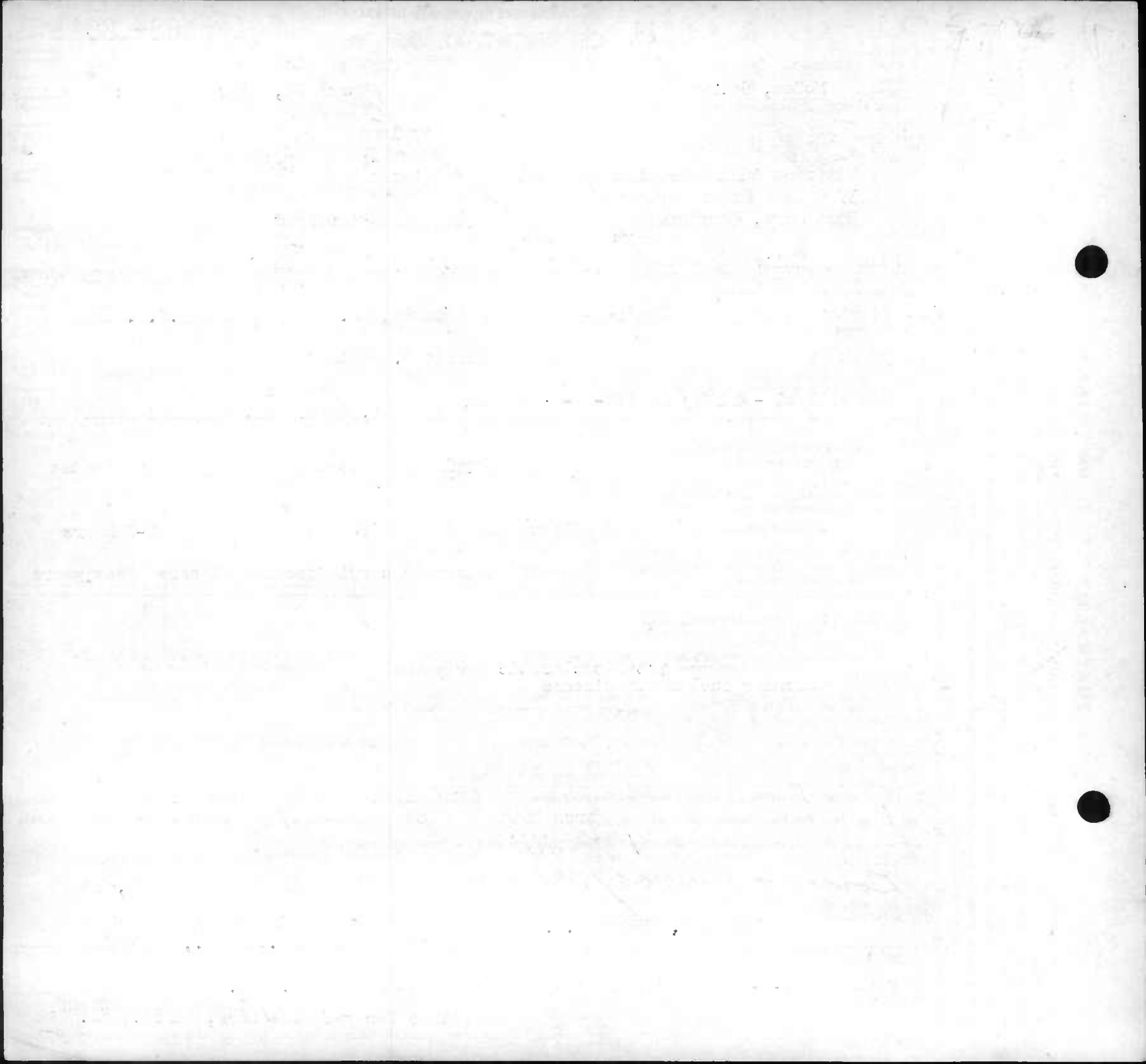
BIRTH NO. 570		1. NAME OF DECEASED (Type or Print) <b>Pauline J Ettien</b>		2. DATE AND HOUR OF DEATH <b>March 29, 1968</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		28-04	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>839 N. Chapelgate Lane Baltimore, Maryland</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>839 N. Chapel Gate Lane</b>		5. SEX <b>Female</b>		6. RACE <b>Whitem</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1910</b>		9. AGE (In years last birthday) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Joseph Plume</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leah Moody, 839 Chapel Gate Lane</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Embolism</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arterial Thromboses</b> <b>MYELOID Metaplasia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 HOURS</b> <b>uncertain</b> <b>6 YEARS</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>299X II</b> <b>Arterial Fibrillation</b>		20. DATE OF OPERATION <b>9/25/67</b>		21. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SPLEENECTOMY (7 pounds)</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>JULY 28</b> 19 <b>67</b> to <b>MARCH 29</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>MARCH 28</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Melvin N. Borden M.D.</b> DEGREE		23B. DATE SIGNED <b>3/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Melvin N. Borden, M. D.</b> DEGREE		23D. ADDRESS <b>5000 Baltimore National Pike</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Paul Evangelical</b>	
24D. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR <b>W. H. 4101 Edmondson Ave.</b>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-3511	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>McGee, George James</b>				March 28, 1968 2:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto Co 53-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>403 Westshire Road</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/03</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fire Fighter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McGee</b>				14. MOTHER'S MAIDEN NAME <b>Mollie L. Warters</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 9/12/42 - 10/28/44</b>				16. SOCIAL SECURITY NO. <b>218-36-8941</b>		17. INFORMANT <b>Records</b>	
				ADDRESS <b>VA Hospital, Baltimore, Maryland 21218</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial infarction</b> <b>Arteriosclerotic cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 Minutes</b> <b>2-3 hours</b> <b>Many years</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>Arteriosclerotic peripheral vascular occlusive disease</b>							
19A. DATE OF OPERATION <b>3/28/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arteriosclerotic peripheral vascular occlusive disease</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? <input type="checkbox"/>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 17th</b> 19 <b>68</b> to <b>March 28th</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 28th</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (d/d/y) view the body after death.							
23A. SIGNATURE <b>Gordon F. Murray M.D.</b>						23B. DATE SIGNED <b>March 29, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>GORDON F. MURRAY M.D.</b>						23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Balto., Md 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-1-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

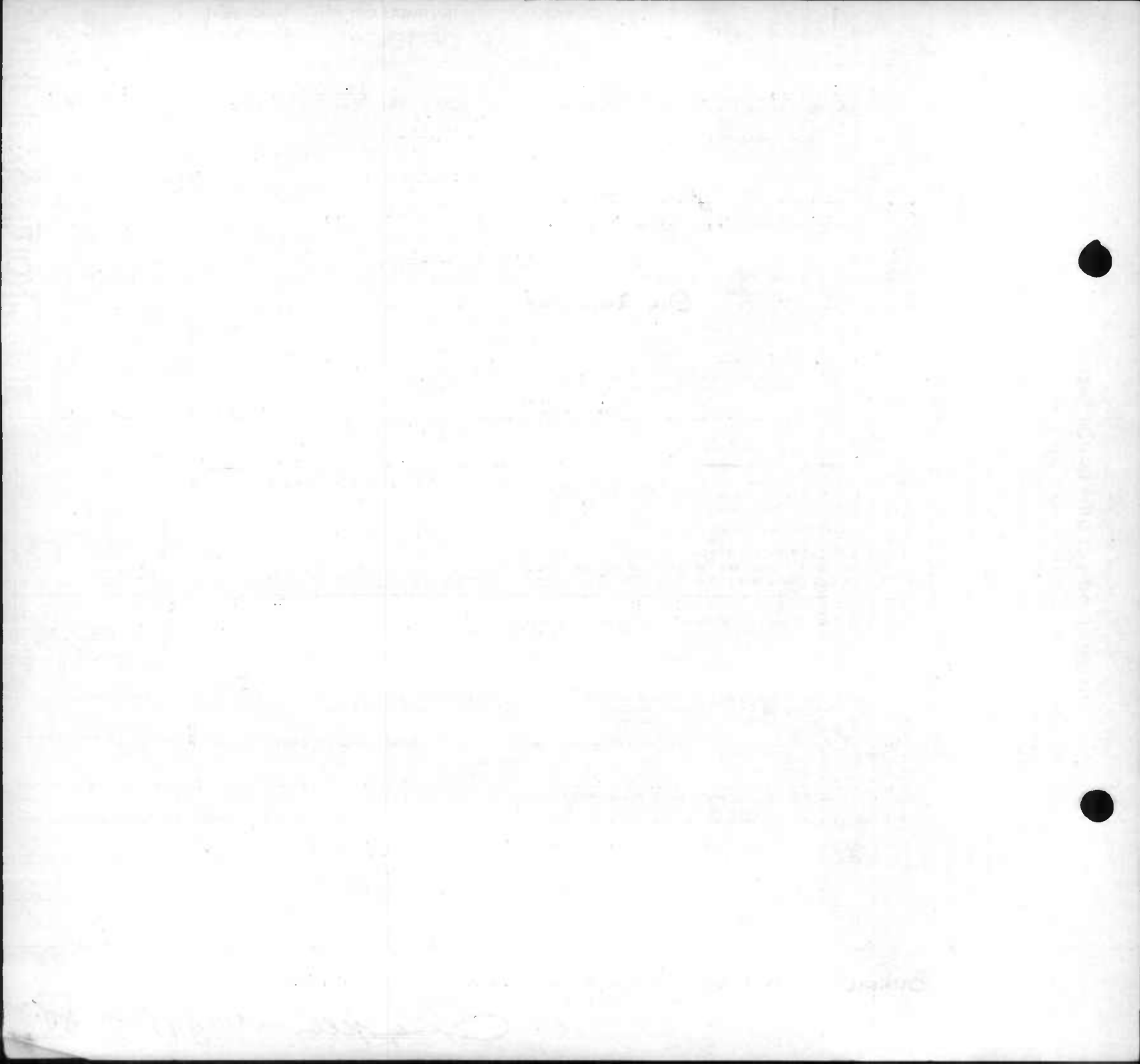
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3512

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3512

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Buechler, Charles Frederick</u>		2. DATE AND HOUR OF DEATH <u>March 29, 1968</u>   <u>10:45</u> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		5. CITY OR TOWN <u>Baltimore</u> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>X U.S. Public Health Service Hospital</u> <u>3100 Wyman Park Dr., Baltimore, Md.</u>		6. STREET AND NUMBER <u>3712 Falt Ave.,</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-8-1885</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sheet metal worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OIL INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles F. Buechler</u>		14. MOTHER'S MAIDEN NAME <u>Julia Messinger</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 01 4326</u>		17. INFORMANT <u>Records USPHS Hospital, Baltimore, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 II</u> <u>Cardiac Tamponade secondary to rupture of lt. ventricle of heart - posteriorly</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Approx. 10 days</u> <u>Years</u> <u>Years</u>	
19. DATE OF OPERATION <u>4-20-68</u>		20. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kenny S. Curt, M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Kenny S. Curt, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-1-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN CEM.</u>	
24D. LOCATION (City, town, or county) <u>BALTO., MD.</u>		24E. LOCATION (State) <u>BALTO., MD.</u>		24F. LOCATION (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Stacy Miller - 2334 Jefferson St.</u>	



M-420

68- 3513

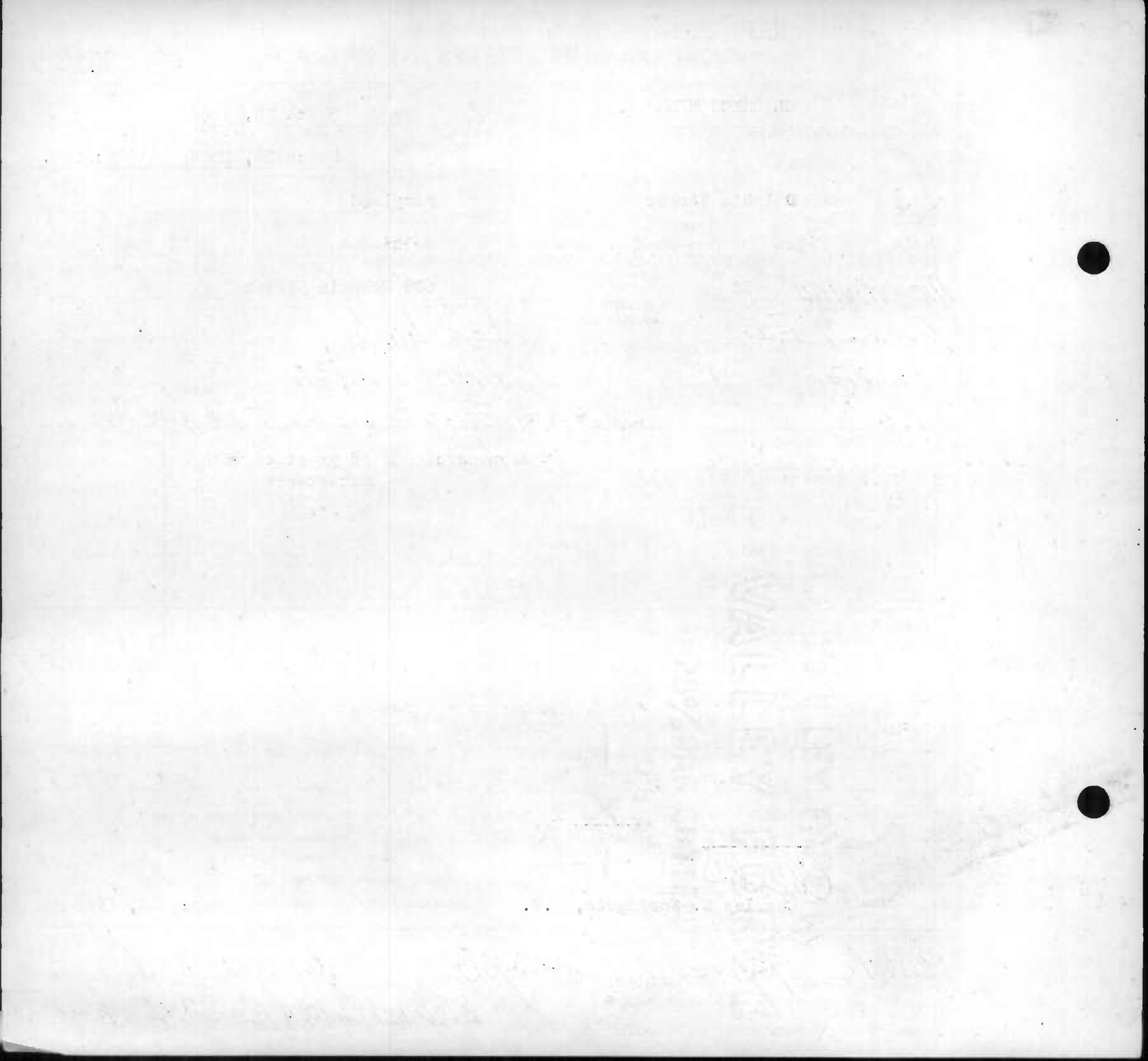
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3513

BIRTH NO.

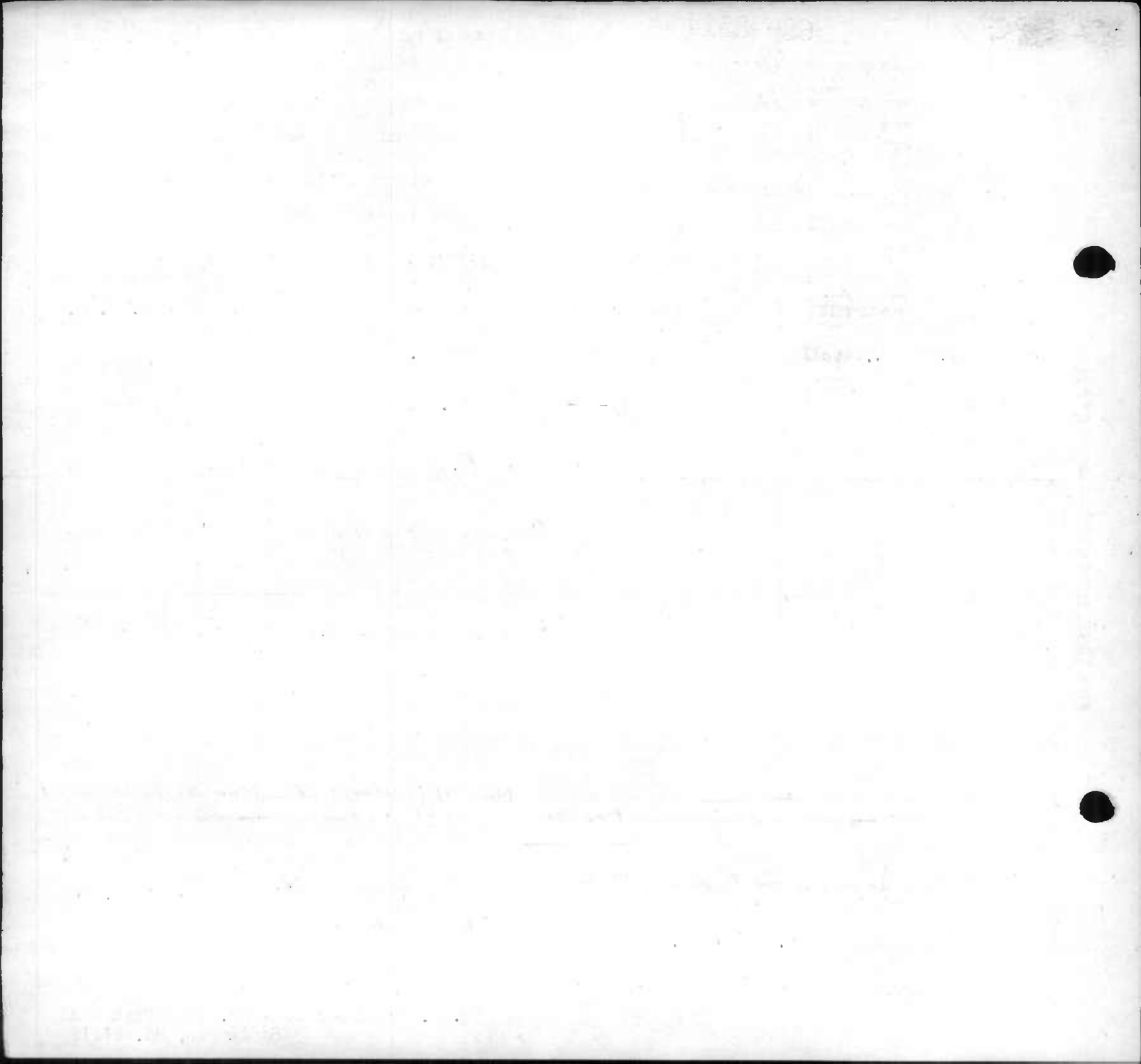
1. NAME OF DECEASED (Type or Print) <b>CLARENCE MILLS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 28, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 608 Dolphin Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 28, 1968 12:55 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-07</b>	
9. DATE OF BIRTH <b>March 16, 1910</b>		10. AGE (In years lost birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Worwood La.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lee Mills</b>		14. MOTHER'S MAIDEN NAME <b>Mary Horton</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>25-4-4761</b>		18. INFORMANT <b>Effie Penn 2615 Guilford Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma of prostate with metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>173X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 28, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>W. Calvary Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Cedar Hill Md.</b>	
25A. DATE REC'D BY HEALTH DEPT <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>3197 Schenck St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 3514					CERTIFICATE OF DEATH				
BIRTH NO.					REG. NO. 68- 3514				
1. NAME OF DECEASED (Type or Print) <b>WOOLLEY MARIE SMITH</b>					2. DATE AND HOUR OF DEATH <b>MARCH 31, 1968 2:55 PM.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL INC.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore 21212</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>604 Anneslie Road</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/27/1890</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David W. Woolley</b>					14. MOTHER'S MAIDEN NAME <b>Mary J. Nixon</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-48-9665</b>		17. INFORMANT <b>Mrs. Ellen Woolley</b>			ADDRESS <b>(Same)</b>	
18. <b>285.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PNEUMONIA, LEFT LOWER LOBE</b> (B) <b>ANEMIA - ? ETIOLOGY</b> (C) _____ DISEASES OR CONDITIONS, if only, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>293X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>RENAL ABSCESSSES</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>YEARS</b> <b>2</b>				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>MAR. 31 (1:30 AM) 1968</b> to <b>MAR. 31 (2:55 PM) 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>MAR. 31 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Jeanne S. Kraus, M.D.</b>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>March 31, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Jeanne S. Kraus</b>					23D. ADDRESS <b>MERCY HOSPITAL, BALTO. Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>			25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Road Baltimore, Md. 21212</b>				



B-6501

68-3515

BALTIMORE CITY HEALTH DEPARTMENT

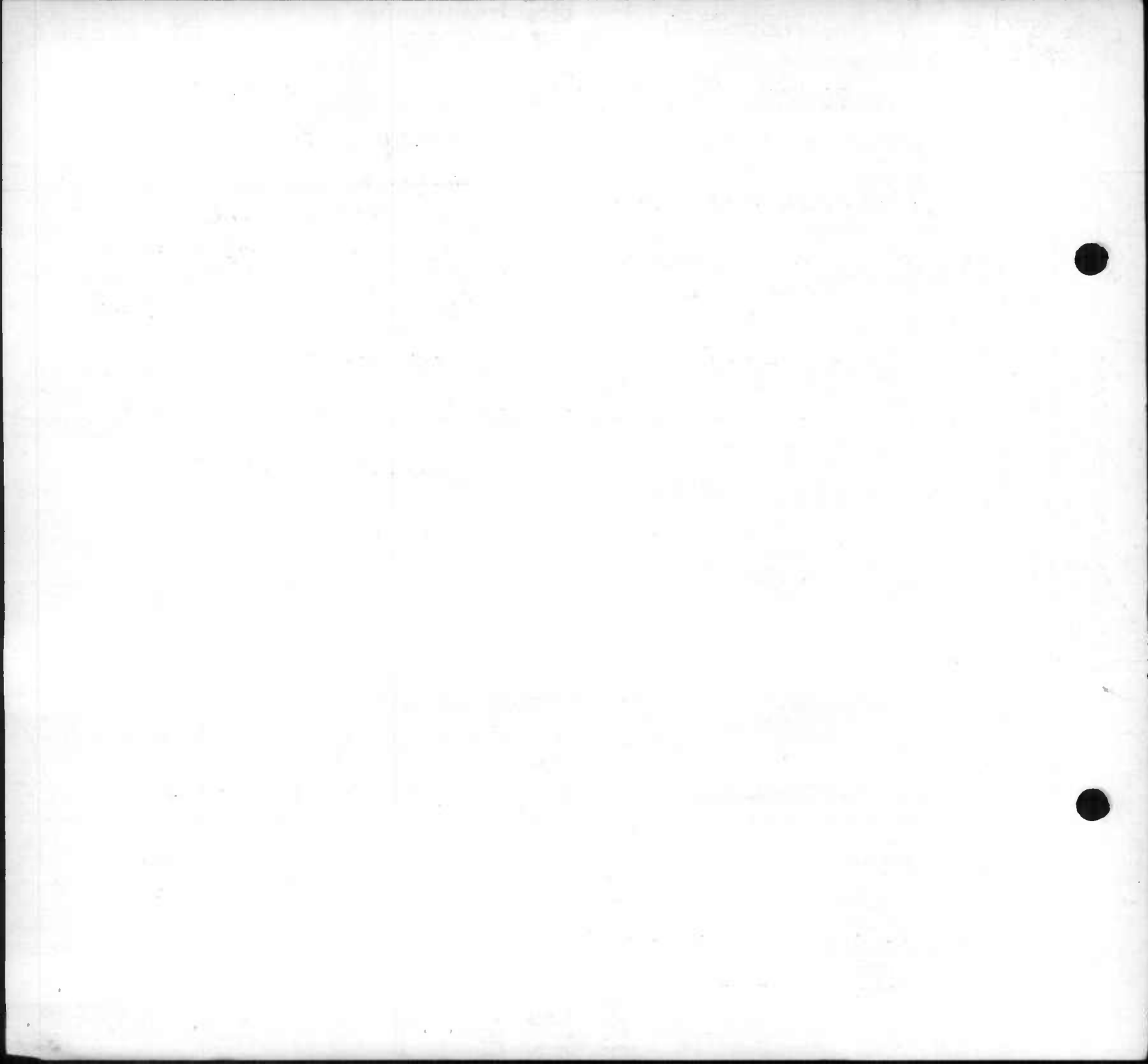
CERTIFICATE OF DEATH

REG. NO. 68-3515

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BROWNE, MARGARET J.</b>		2. DATE AND HOUR OF DEATH <b>3-27-68</b> <b>8:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>311 Stevenson Lane</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>04-17-91</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —		9. AGE (In years last birthday) <b>76</b>	
13. FATHER'S NAME <b>HENRY LILLY</b>		14. MOTHER'S MAIDEN NAME <b>MARY HELEN JENKINS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-24-0444</b>		17. INFORMANT <b>MRS. P. J. MONEGHAN</b>	
18. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular accident</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-14-1968</b> to <b>3-27-1968</b> , that (I) (we) lost saw the deceased alive on <b>3-27-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sarant Sifungfung, M.D.</b>				23B. DATE SIGNED <b>3-27-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALFRED G. OSMAN, JR.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-20-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION <b>Baltimore</b>		24E. STATE <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3516

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEROY GARY (GRAY)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1968</b> 10:32 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>HOPKINS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 30, 1968</b> 10:32 P.M.	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Dec. 22, 1911</b>		10. AGE (In years lost birthday) <b>56</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>248-10-1616</b>	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS <b>Mrs. Flossie Dean 707 E. 21st Street</b>	
19. <b>441.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Dissecting Aneurysm of Aorta</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4/4/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Roland N. Kornblum, M.D.</b> DATE SIGNED <b>3-31-68</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/4/68</b>	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Florence, South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Roland E. Fackler</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	

WALTER

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3517	
B-633		68-3517		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Virginia Broadwater</i>		2. DATE AND HOUR OF DEATH <i>3-28-68</i> <i>1 45</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>25 B. West Way North</i> <i>21221</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-6-1919</i>	9. AGE (In years last birthday) <i>48</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Food</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Winters</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Lee</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue 21224</i>	
18. <i>412.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>sub-arachnoid hemorrhage</i> (B) <i>right posterior communicating artery</i> DUE TO, OR AS A CONSEQUENCE OF: <i>aneurysm</i> (C) <i>HTASCD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>443 X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-26</i> 19 <i>68</i> to <i>3-28</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>3-28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mark Lowmiller</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3-28-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mark Lowmiller</i>		23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Baltimore, Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-30-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Washington National Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>		24E. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i>		24F. ADDRESS <i>4308 Suitland Rd. SE, Washington, D.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1 M-250 68- 3518 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 68- 3518

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NICHOLAS MUCYN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>March 28, 1968</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3036 Hudson Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 28, 1968</b>		Hour <b>9:07 A.</b>		M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>Dec. 7, 1897</b>		10. AGE (In years lost birthday) <b>70</b>		11. BIRTHPLACE (State or foreign country) <b>Ukraine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Mucyn</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		15. MOTHER'S MAIDEN NAME <b>Catherine</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>219-32-1046</b>		18. INFORMANT <b>Mrs. Pauline Mucyn</b>		19. ADDRESS <b>3036 Hudson Street</b>		20. CAUSE OF DEATH <b>Artériosclerotic cardiovascular disease</b>	
21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Artériosclerotic cardiovascular disease</b>		23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>432.1 II</b>		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
25. DATE OF OPERATION <b>0</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) <b>No</b>		28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
33. HOW DID INJURY OCCUR?		34. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		35. ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>March 28, 1968</b>	
37. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		38. DATE <b>4-1-1968</b>		39. NAME of CEMETERY or CREMATORY <b>Lorraine Mausoleum</b>		40. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
41. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		42. NAME OF REGISTRAR <b>Robert E. Fisher</b>		43. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		44. ADDRESS <b>1901-07 Eastern Ave.</b>	

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M-450 68- 3519 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68- 3519

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAM M. MILAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b>		Hour <b>6:40 P</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 29, 1968</b>		Hour <b>6:40 P</b>		M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>AUG. 26, 1943</b>		10. AGE (In years lost birthday) <b>24</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARTNER-OPERATOR</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		15. MOTHER'S MAIDEN NAME <b>ELEANOR MCGREEVY</b>		E. STREET AND NUMBER <b>5111 Plainfield Avenue</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>219-42-0825</b>		18. INFORMANT <b>VINCENT W. MILAN</b>		ADDRESS <b>5111 PLAINFIELD AVE #21206</b>	
19. <b>E-891X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>E916.6 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>70% Body Burns</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Streets</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Elliott Street and Highland Avenue</b>			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>3 28 68 6:10p</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. trapped in building</b>		<b>26-09</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>3-30-68</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>APR. 2 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM. BALTO. MD.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>DIPPEL BROS. INC.</b>		ADDRESS <b>7110 BELAIR RD. #21206</b>	

WALTER BOWEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

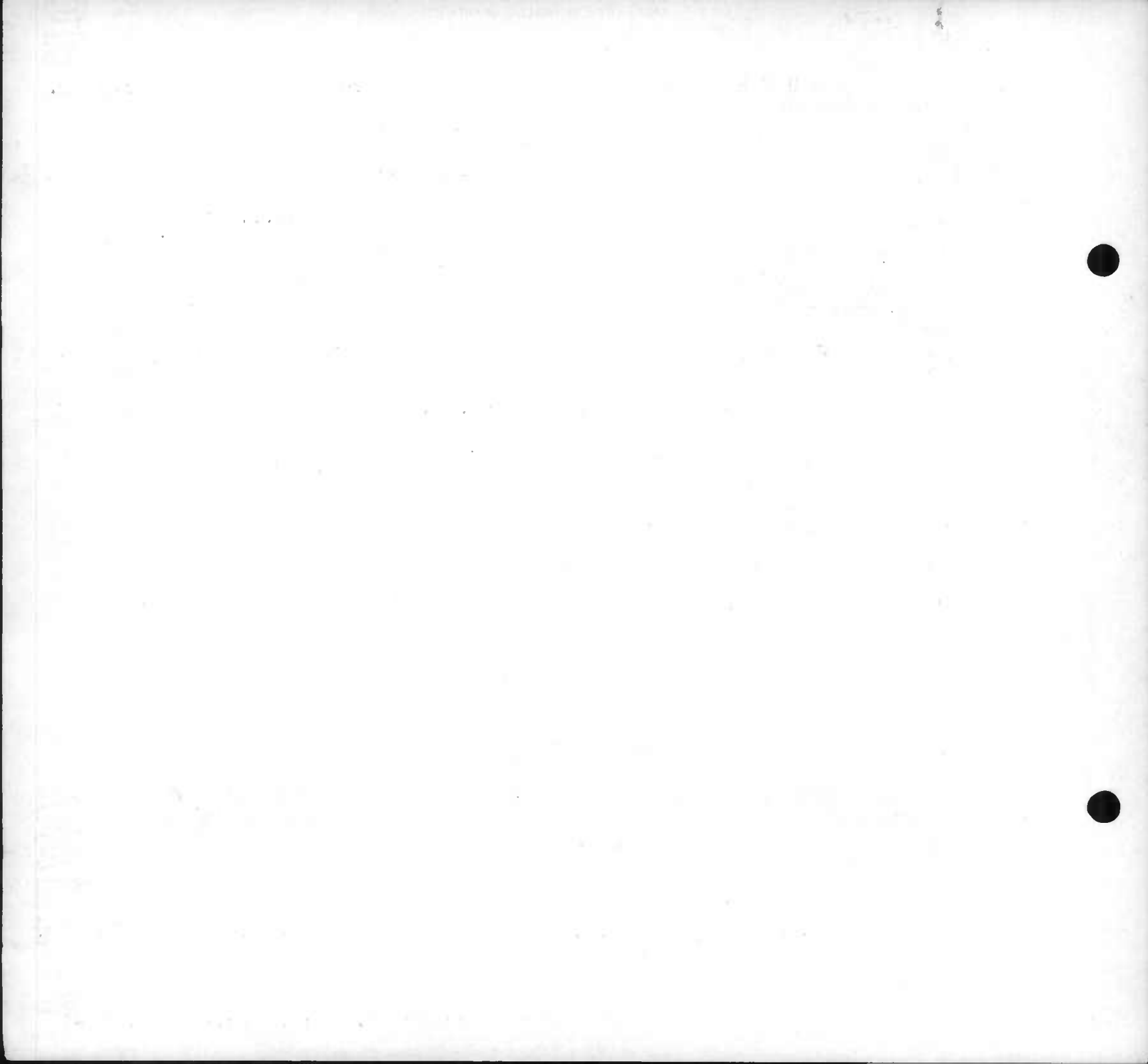
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68- 3520</u>	
H-324 68-- 3520		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Margaret B Hetzel</u>		2. DATE AND HOUR OF DEATH <u>March 30, 1968</u> <u>8:08 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2802 White Ave</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2802 White Ave</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1883</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Krause</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Eleanor M. Hetzel- Same</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/2/9 I</u> <u>Brachio pneumonia</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebrovascular insufficiency 5 yrs.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Acute Psychosis 10 yrs.</u> <u>intermittent</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs?</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>4/2/1 II</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> <u>1967</u> to <u>3/30</u> <u>1968</u> . that (I) (we) last saw the deceased alive on <u>1/29</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Isadore Karl Grossman</u>		23B. DATE SIGNED <u>4/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Isadore Karl Grossman M.D.</u>		23D. ADDRESS <u>1527 East North Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/2/68</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>	
25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc</u>		ADDRESS <u>Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

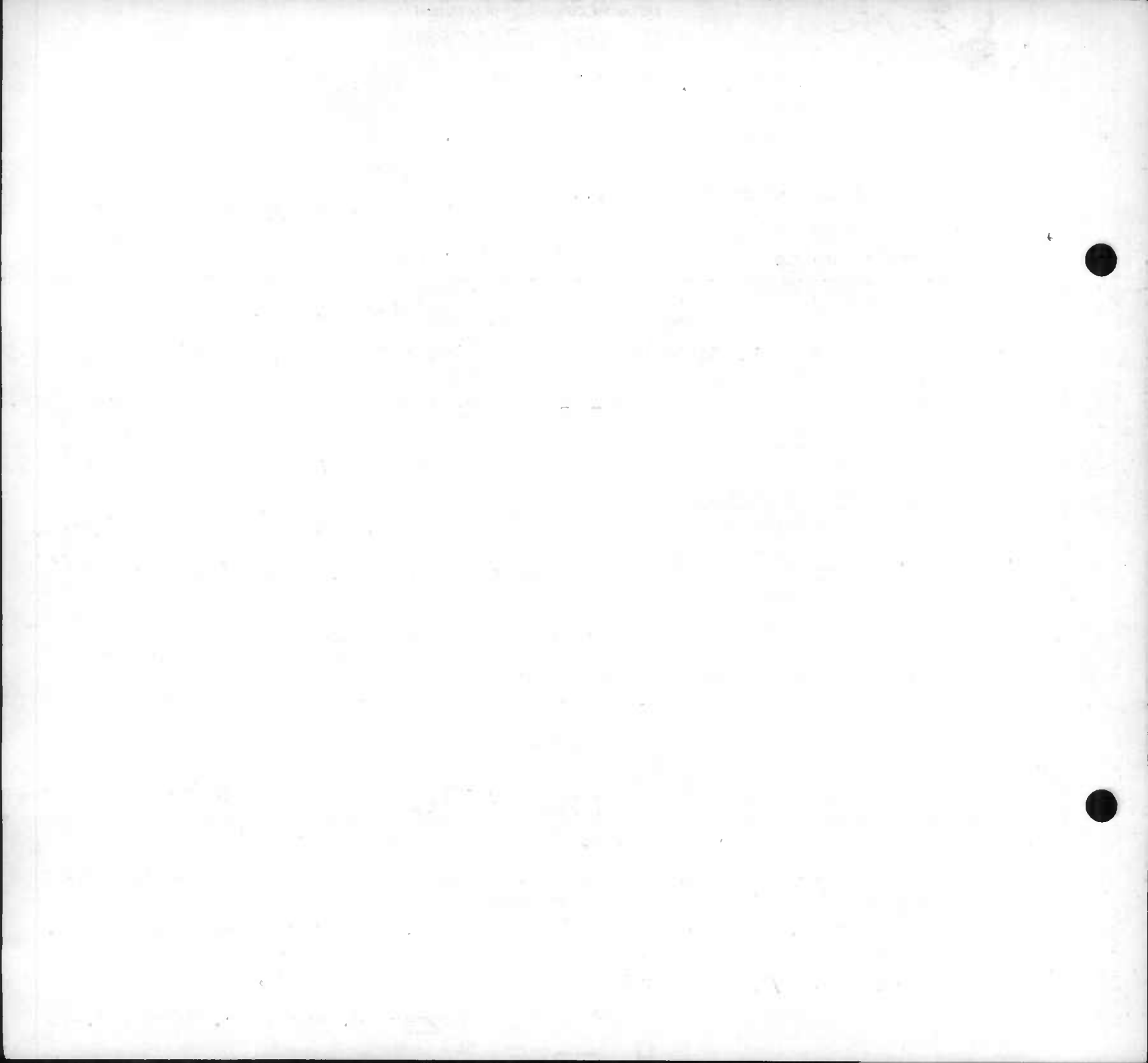
BALTIMORE CITY HEALTH DEPARTMENT				W-452 68-3521		BIRTH NO.	
CITY HEALTH DEPARTMENT				CITY HEALTH DEPARTMENT		CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) <b>RUTH E. WILLIAMS</b>				2. DATE AND HOUR OF DEATH <b>March 31, 1968 1:15 a. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6408 Alta Avenue</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
5. SEX <b>female</b>				6. RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3/21/1898</b>				9. AGE (In years last birthday) <b>70</b>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Moses Hale</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Wollard</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216169238B</b>		17. INFORMANT ADDRESS <b>Mr. G. Stanley Williams- Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Colon with Metastases</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 19 67</b> to <b>3/30 19 68</b> , that (I) (we) last saw the deceased alive on <b>3/30 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.							
23A. SIGNATURE <b>Sol Smith</b>				23B. DATE SIGNED <b>3/31/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Sol Smith, M.D.</b>				23D. ADDRESS <b>1261 Belvedere Ave. (East)-Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.-Balto, Md-14</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-- 3522</u>
BIRTH NO. <u>F-450</u>		68- 3522 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>LOIS K. FALLANO</u>		2. DATE AND HOUR OF DEATH <u>March 29, 1968</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>3014 Oakcrest Avenue...34</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY  C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <u>3014 Oakcrest Avenue</u>		
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1911</u>	9. AGE (In years last birthday) <u>56</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Stuart Patrick Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John R. Gilbert</u>		14. MOTHER'S MAIDEN NAME <u>Ida Elizabeth Wiggington</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-01-8406</u>	17. INFORMANT ADDRESS <u>Mr. Anthony Fallano: 3014 Oakcrest Ave.</u>	
18. <u>1830 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Ca of ovary:-</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastasis to peritoneum-</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Antigenic protein function</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u> <u>2 years</u> <u>6 mos.</u>
1750 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>Sept 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intest. CPB function</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1937</u> to <u>3/29</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.				
23A. SIGNATURE <u>Sol Smith</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/30/68</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. Sol Smith</u>		23D. ADDRESS <u>1261 E. Belvedere Ave, Baltimore, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/2/68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbanks</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc, Balto, Md.-14</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

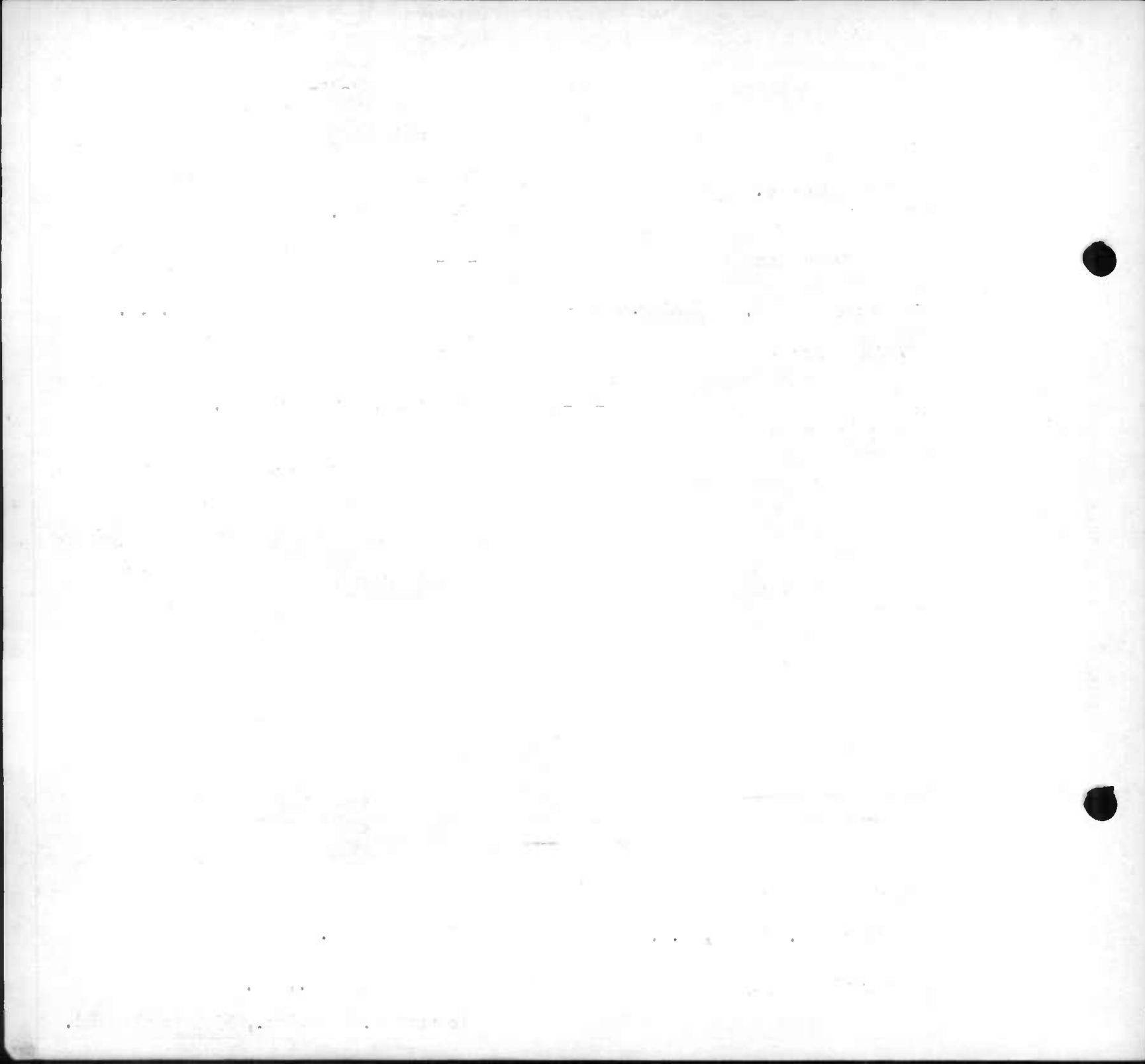
B-525		68-3523		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-3523	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED Catherine M. Benson				2. DATE AND HOUR OF DEATH 3/31/1968 7:15 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 42 Sinai Hospital of Baltimore, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Md. Baltimore Co. 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Monkton			
D. STREET ADDRESS (If rural, give location) Rural- Monkton Rd.- Monkton Md.							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 9/22/1959	9. AGE (In years last birthday) 8	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX - NONE		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilton A. Benson				14. MOTHER'S MAIDEN NAME Madelin Kostens			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart - Mr. Wilton A. Benson- Monkton Rd.-		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 3575.91 Aspiration Pneumonia.				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Due to Profound Coma			
				(C) Due to Prolonged Cerebral Anoxia during Seizure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 3575 X II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1, 1968 to March 31, 1968, that (II) (we) last saw the deceased alive on 11 PM 3/30/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE I. Meyer Heller				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/31/1968	
23C. PHYSICIAN'S NAME (Type) I. Meyer Heller				23D. ADDRESS Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/68		24C. NAME OF CEMETERY or CREMATORY Immanuel Luth. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.- Balto. Md.		ADDRESS -14	

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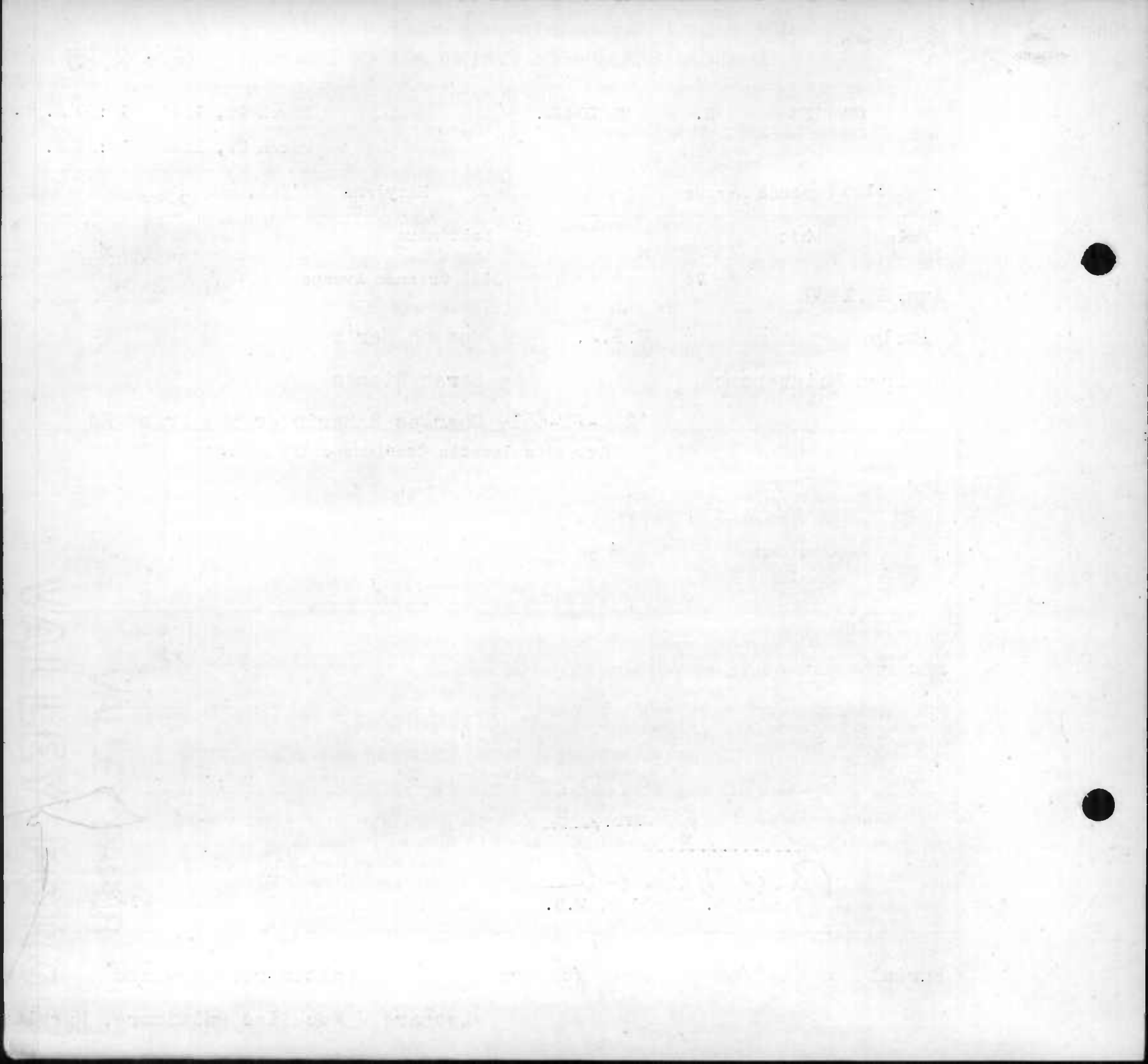
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3524</span>	
<div style="display: flex; justify-content: space-between;"> <span>5-310</span> <span>68- 3524</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		Bernard Staab		2. DATE AND HOUR OF DEATH 3-28-68 4:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5306 Nuth Ave.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5306 Nuth Ave.					
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Ret.		10B. KIND OF BUSINESS OR INDUSTRY Sealtest Dairy		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Louis Staab		14. MOTHER'S MAIDEN NAME Margaret Horman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-8251		17. INFORMANT ADDRESS Anna Staab, 5306 Nuth Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema (B) Cardio-Vascular Hypertensive Disease (C) Arteriosclerosis Carcinoma Prostate		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 6 years 6 years 3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1963 to March 28 1968, that (I) last saw the deceased alive on Feb. 21, 1968 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Michael J. Dausch M.D.		23B. DATE SIGNED March 29, 1968			
23C. PHYSICIAN'S NAME (Type) Michael J. Dausch, M.D.		23D. ADDRESS 4636 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.	



1  
5-600 68-3525 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-3525

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES R. SERIO SR.		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> March 29, 1968		Hour 10:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3100 Oreando Avenue		3. DATE PRONOUNCED DEAD March 29, 1968		Hour 10:50 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-05	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Aug. 28, 1889		10. AGE (In years last birthday) 78		E. STREET AND NUMBER 3100 Oreando Avenue		ORLANDO AVE	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Serio			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Sarah Bionda			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-01-6619		18. INFORMANT Charles R Serio Jr		ADDRESS 503 Brook Rd	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-29-68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/2/68		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 1 1968		25B. NAME OF REGISTRAR Robert E. J...		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland			



B-260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES BAKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1968</b> 9:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>203 N. Patterson Park Avenue (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 30, 1968</b> 9:00 P. M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Feb 25/92</b>		10. AGE (In years lost birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garb</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Bald Ltd</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2</b>		17. SOCIAL SECURITY NO. <b>212-20-2677</b>	
18. INFORMANT <b>Mary L. Baker</b>		ADDRESS <b>3101 Pelham Ave</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>	
20A. DATE OF OPERATION <b>4/12/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4/3/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Bald N. A. Stearns</b>		24D. LOCATION (City, town or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>Philip's New York Sons</b>		ADDRESS <b>3024 Orleans St</b>	

THE UNIVERSITY OF CHICAGO

CHICAGO, ILLINOIS

W.A.

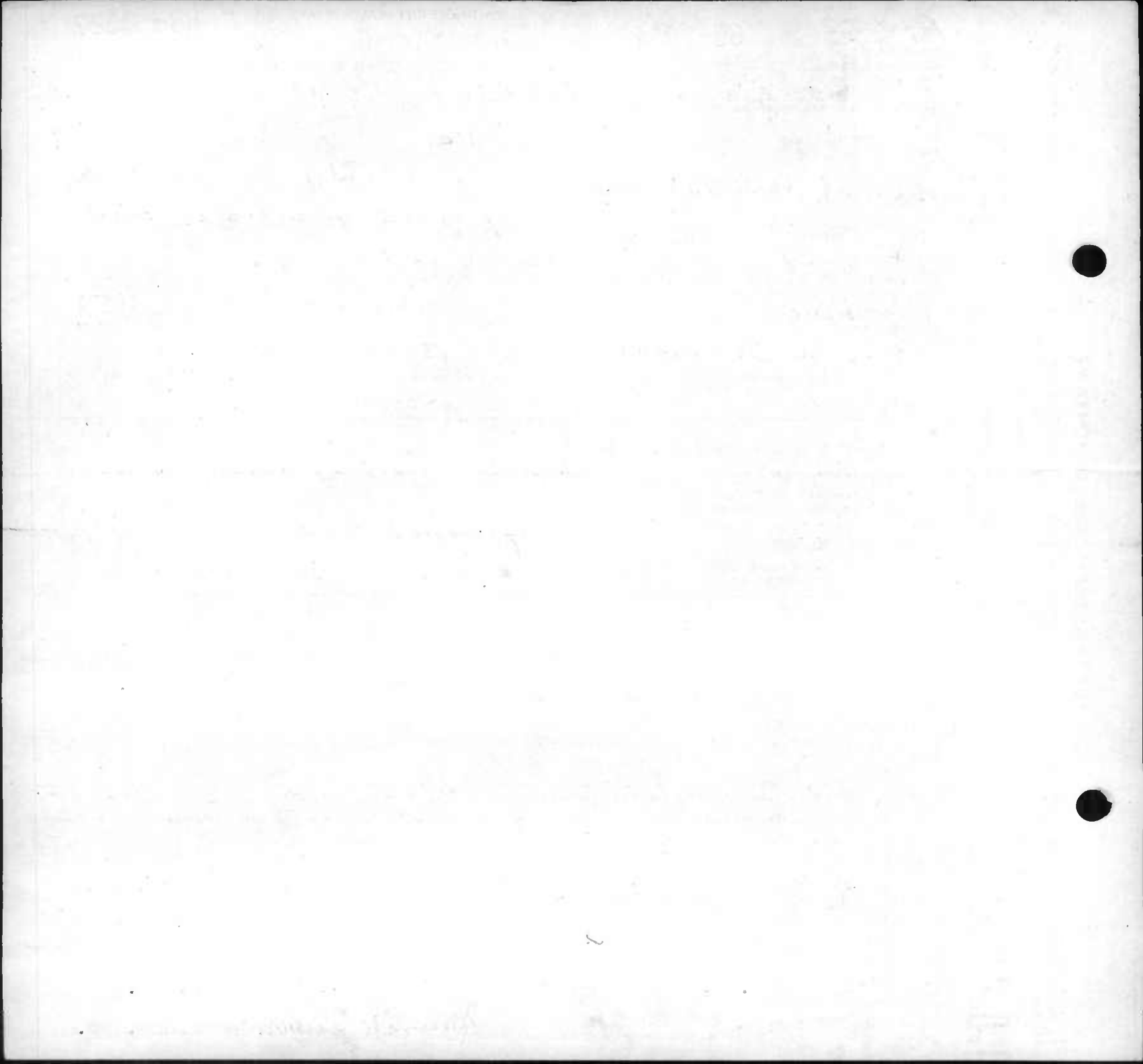
THE UNIVERSITY OF CHICAGO

CHICAGO, ILLINOIS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3527	
11-633		68-3527		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Georgia S. Meredith</i>		2. DATE AND HOUR OF DEATH <i>3/26/68 7:15 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Dorchester</i>		5. SEX <i>F</i> 6. RACE <i>W</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. of Maryland Hosp.</i>		C. CITY OR TOWN <i>Cambridge</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>1305 Hambrooks Blvd.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/16/90</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>77</i>	
13. FATHER'S NAME <i>George Sherman</i>		14. MOTHER'S MAIDEN NAME <i>Ida Gambrell</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
17. INFORMANT <i>Hospital chart</i>		ADDRESS			
18. <i>4/12/9 + L 202.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i> (B) <i>probable A.S.H.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>possible lymphoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>202.1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>3/26</i> 19 <i>68</i> to <i>3/26</i> 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>3/26</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>S.L. Markowitz, M.D.</i>		23B. DATE SIGNED <i>3/26/68</i>		23C. PHYSICIAN'S NAME (Type) <i>S.L. Markowitz, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar. 28, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Dorchester Memorial Park, Cambridge, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 1 1968</i>		25B. NAME OF REGISTRAR <i>R.D. &amp; E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Funeral Home</i>	
				ADDRESS <i>Cambridge, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				68- 3528	
D-620				68- 3528	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		James Orton Dorsey		2. DATE AND HOUR OF DEATH 3-30-68 6 <sup>30</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md.	
B. COUNTY Baltimore		C. CITY OR TOWN Owings Mills		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-25-97		9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Dorsey	
14. MOTHER'S MAIDEN NAME Fannie Stocksdaie		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 01 2429	
17. INFORMANT Mrs. Margaret F. Dorsey		18. CAUSE OF DEATH Massive Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? Phlebotomosis - Lower limbs		? few weeks	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 466x II		22. DATE OF OPERATION 3-26-68		23. CONDITION FOR WHICH OPERATION WAS PERFORMED Mucocele of appendix	
24. AUTOPSY? (Yes or No) NO		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. HOW DID INJURY OCCUR?	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		32. I certify that (I) (this hospital) attended the deceased from 2-29 1968 to 3-30 1968, that (I) (we) last saw the deceased alive on 3-30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.	
33. SIGNATURE Krishna Reddy		34. DATE SIGNED 3/30/68		35. PHYSICIAN'S NAME (Type) KRISHNA REDDY	
36. ADDRESS Church Home & Hospital, Baltimore.		37. BURIAL CREMATION, REMOVAL (Specify) Burial		38. DATE 4/3/68	
39. NAME OF CEMETERY or CREMATORY Morgan Chapel Cemetery		40. LOCATION (City, town, or county) Carroll Co. Md.		41. STATE (State)	
42. DATE REC'D BY HEALTH DEPT. APR 1 1968		43. NAME OF REGISTRAR J. F. Eline & Sons		44. FUNERAL DIRECTOR Reisterstown, Md.	

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James Dorsey  
Fannie Stockdale  
also 012489

Policeman

M W

8-22-47 40

Md.

N.S.

Church Home and Hospital  
10311 Reisterstown Rd.  
Owings Mills

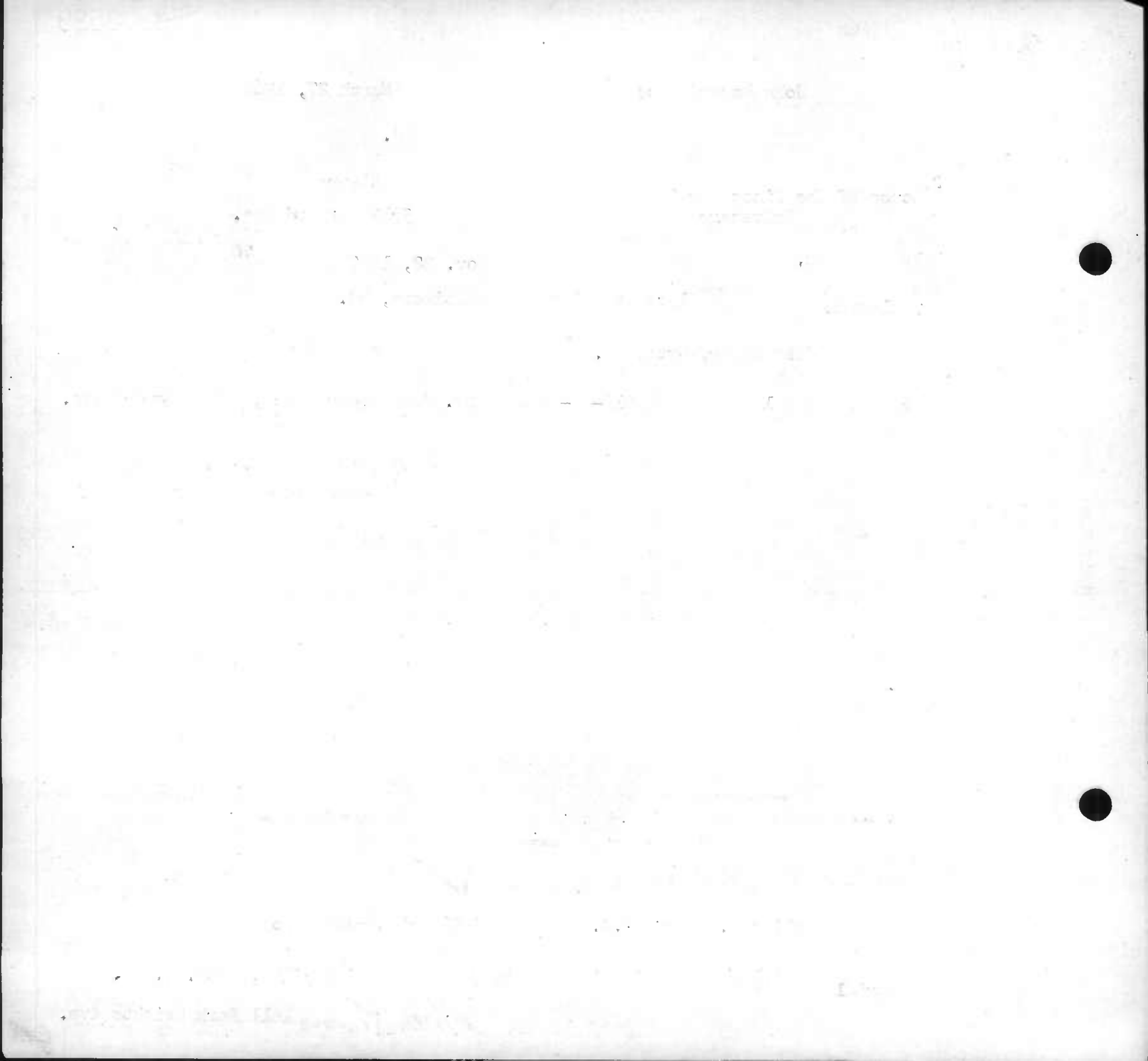
Md.

James Dorsey

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BIRTH NO. <span style="float: right;">N-200</span>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">68- 3529</span>	
1. NAME OF DECEASED (Type or Print) <b>John Howard Nyce</b>				2. DATE AND HOUR OF DEATH <b>March 27, 1968</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House Of The Pines Nursing Home Belvedere</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3513 Hayward Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1897</b>		9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Floor Covering</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Howard Nyce, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Rose Callahan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> W # <b>1</b>			16. SOCIAL SECURITY NO. <b>215-10-6341A</b>		17. INFORMANT <b>Mrs. John Howard Nyce, 3513 Hayward Ave.</b>		
18. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE - <b>Acute Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>A.S.H.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 1 hour</b> <b>about 5 years</b> <b>about 5 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.0 II Coronary A.S.</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1958</b> 19 to <b>March 27</b> 19 <b>68</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>3/23/68</b> 19 and that in (my) ( <del>last</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>not</del> ) view the body after death.							
23A. SIGNATURE <b>Julius C. Gluck, M.D.</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3/27/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Julius C. Gluck, M.D.</b> DEGREE				23D. ADDRESS <b>5356 Reisterstown Road</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Orlando E. Talbot</b>		25C. FUNERAL DIRECTOR <b>Bernard Lemmon</b>		ADDRESS <b>4611 Park Heights Ave.</b>	



B-340

68- 3530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3530

BIRTH NO.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> March 25, 1968 Hour 6:00 P.M.	
1. NAME OF DECEASED (Type or Print) HELEN E. BATTLE		3. DATE PRONOUNCED DEAD Month Day Year March 26, 1968 Hour 8:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2320 Hunter Street		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX female	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 2/21-97		10. AGE (In years) 77 1/4	
11. BIRTHPLACE (State or foreign country) Carroll Co Ind		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
15. MOTHER'S MAIDEN NAME Alice Ann Battle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown	
17. SOCIAL SECURITY NO. 220-14-1429		18. INFORMANT ADDRESS Marion Brown, 2317 Hunter St	
19. 412191		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type): Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 3/26/68			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	



M-254 68- 3531

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3531

BIRTH NO.

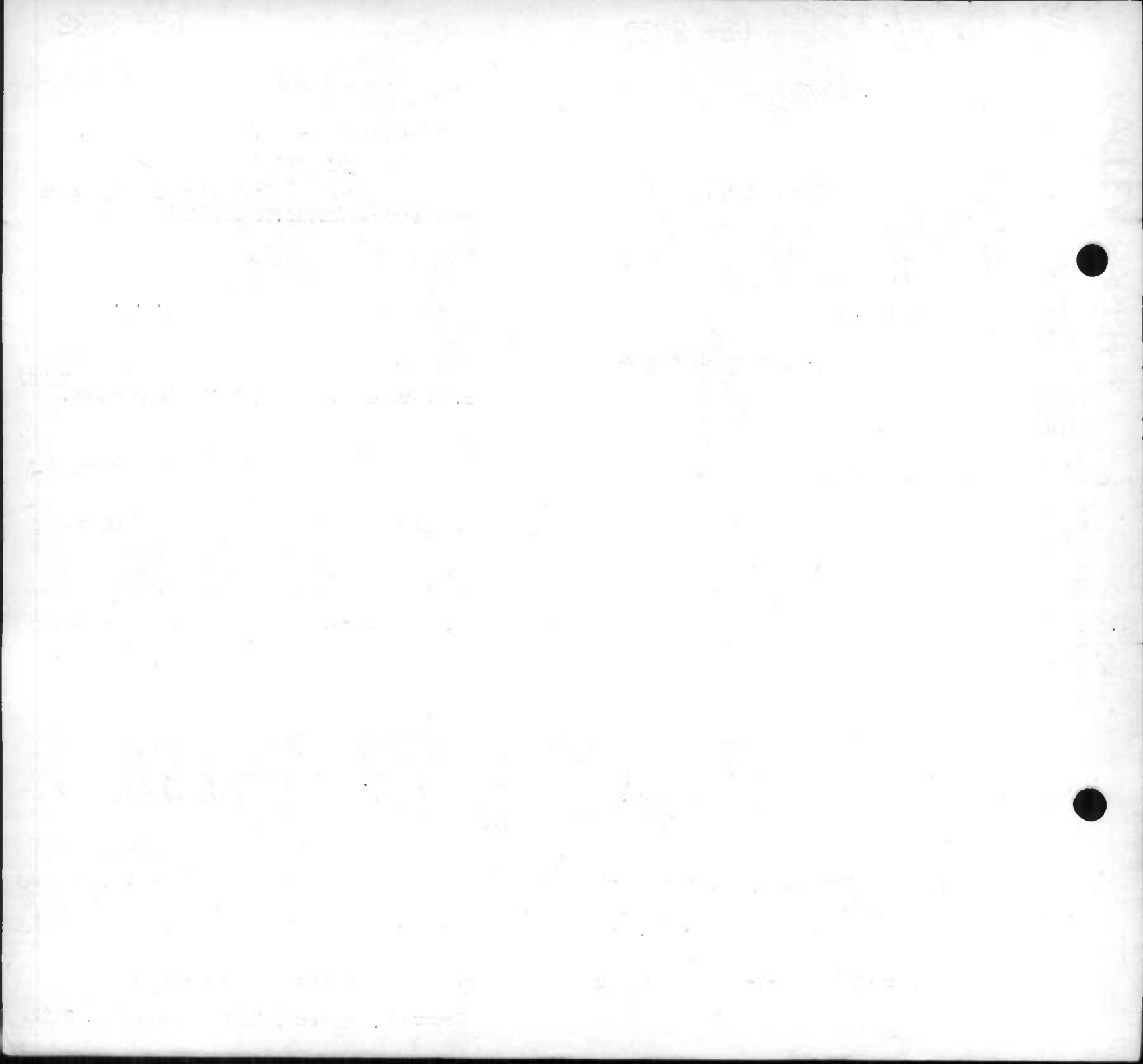
1. NAME OF DECEASED (Type or Print) <b>ANASTASIA A. MAC NEIL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>March</b> Day <b>29</b> Year <b>1968</b> Hour <b>6:03 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>U.S PUBLIC HEALTH HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month <b>March</b> Day <b>29</b> Year <b>1968</b> Hour <b>6:03 P.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
9. DATE OF BIRTH <b>12, 2, 1900</b>		10. AGE (In years last birthday) <b>67</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own Home</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Mary ann McKinnon</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Wm. P. Mac Neil Same as # 5</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>4-2-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-30-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd</b>	

Rev. A. A. Phelps

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

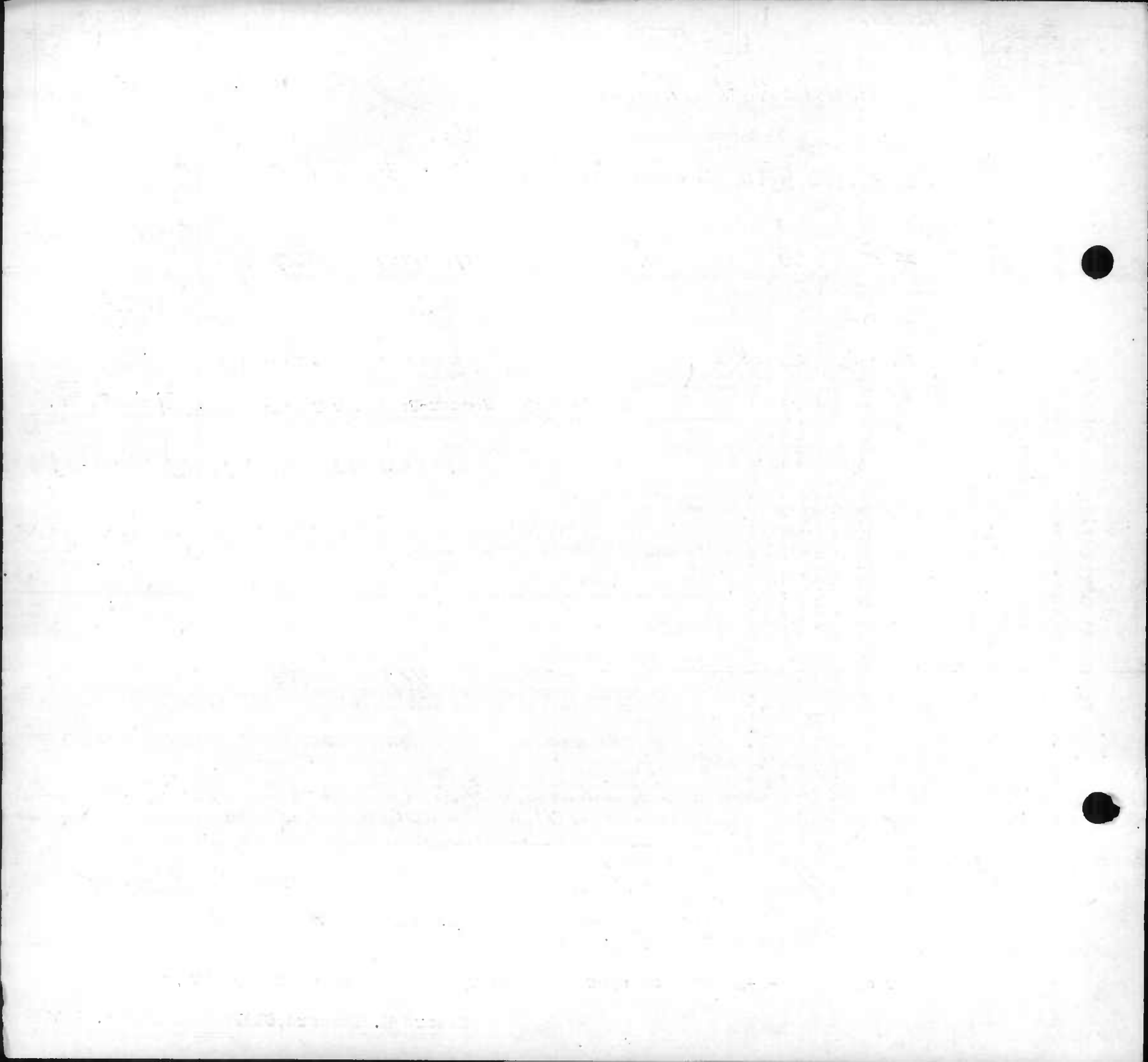
<div style="display: flex; justify-content: space-between;"> <span>M-325</span> <span>68- 3532</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>REG. NO. 68- 3532</span> </div>			
1. NAME OF DECEASED (Type or Print) <i>Mathison Thilda</i>		2. DATE AND HOUR OF DEATH <i>3-29-68 8:40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto Co</i> C. CITY OR TOWN <i>Bethesda</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2809 Pennsylvania Avenue</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/10/85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>82</i>
11. BIRTHPLACE (State or foreign country) <i>Norway</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Theodore Sorensen</i>		14. MOTHER'S MAIDEN NAME <i>Bergette Olson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Lawrence Mathison, 2812 Alabama Ave.</i>		ADDRESS <i>21227</i>	
18. <i>410.94 1250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>MYOCARDIAL INFARCTION</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASC. V.D.</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. DATE OF OPERATION <i>4/20/68</i>		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 29 1968</i> to <i>March 29 1968</i> , that (I) (we) last saw the deceased alive on <i>March 29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Agustin del Campo MD</i>		23B. DATE SIGNED <i>March 29 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN del CAMPO MD</i>		23D. ADDRESS <i>Bon Secours Hosp. Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4-2-1968</i>	24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Howard County, Maryland</i>
25A. DATE REC'D BY HEALTH DEPT. <i>APR 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>	
25C. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">V</span>	68- 3533
<div style="display: flex; justify-content: space-between;"> <span>P-412</span> <span>68- 3533</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Nacomi Ruth Phillips		17 45am March 31 68 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
U.S. Public Health Service Hospital		A. STATE Va. B. COUNTY V-43			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Port Haywood		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
W F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/1/1904	XXX 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
hw				Ind. USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Rufus Brooks		Carrie German			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		213-24-6891		Foster-Faulkner Funeral Home, ADDRESS P.O. Bx 37 Mathews, Va.	
18. 463,911		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cerebral Thrombosis 2 weeks	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) Arteriosclerotic Vascular Disease 2 years			
ANTECEDENT CAUSES		(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/11 19 68 to 3/31 19 68, that (I) (we) last saw the deceased alive on 3/31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Henry S. Crist, M.D. DEGREE				3/31/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Henry S. Crist		USPHS Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Wachaporgue Cemetery		Wachaporgue, Virginia	
24B. DATE		24E. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
4-3-1968		Robert E. Fadden		Howard H. Hubbard, 4107 Wilkens Ave. 21229	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 1 1968					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3534

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3534

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH E. DADE

2. DATE AND HOUR OF DEATH

MARCH 30 1968 9:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNIVERSITY  
38 HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1428 MOUNT MORRIS CT.

5. SEX

M

6. RACE

NEGRO

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/1/06

9. AGE (In years  
lost birthday)

61

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JOSEPH DADE

14. MOTHER'S MAIDEN NAME

NETTIE

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

Carrie Dade

ADDRESS

same

18.

15411

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY INSUFFICIENCY 24 HOURS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) ATLECTASIS + PNEUMONIA 4 DAYS

(C).....

154X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

CARCINOMA OF RECTUM

19A. DATE OF OPERATION

13/26/68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

CANCER OF RECTUM

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/16 1968 to 3/30 1968,  
that (I) (we) last saw the deceased alive on 3/30/68 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles M. Harrison

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

3/30/68

23C. PHYSICIAN'S  
NAME (Type)

CHARLES M. HARRISON MD

23D. ADDRESS

UNIVERSITY HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-4-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 2 1968

25B. NAME OF REGISTRAR

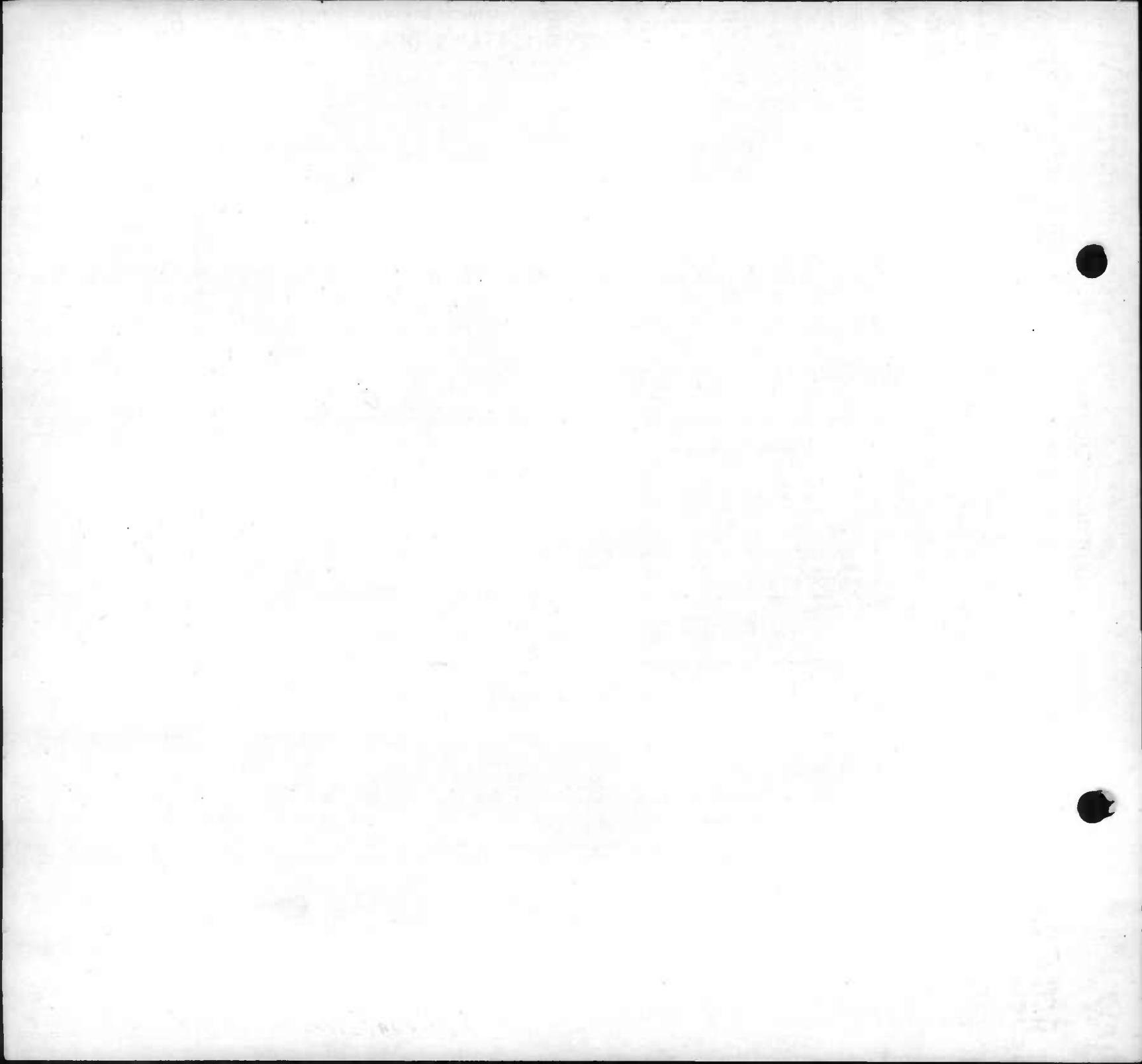
Robert E. Fairbank

25C. FUNERAL DIRECTOR

Sullivan Funeral Home - N. Arlington Ave

1011-13

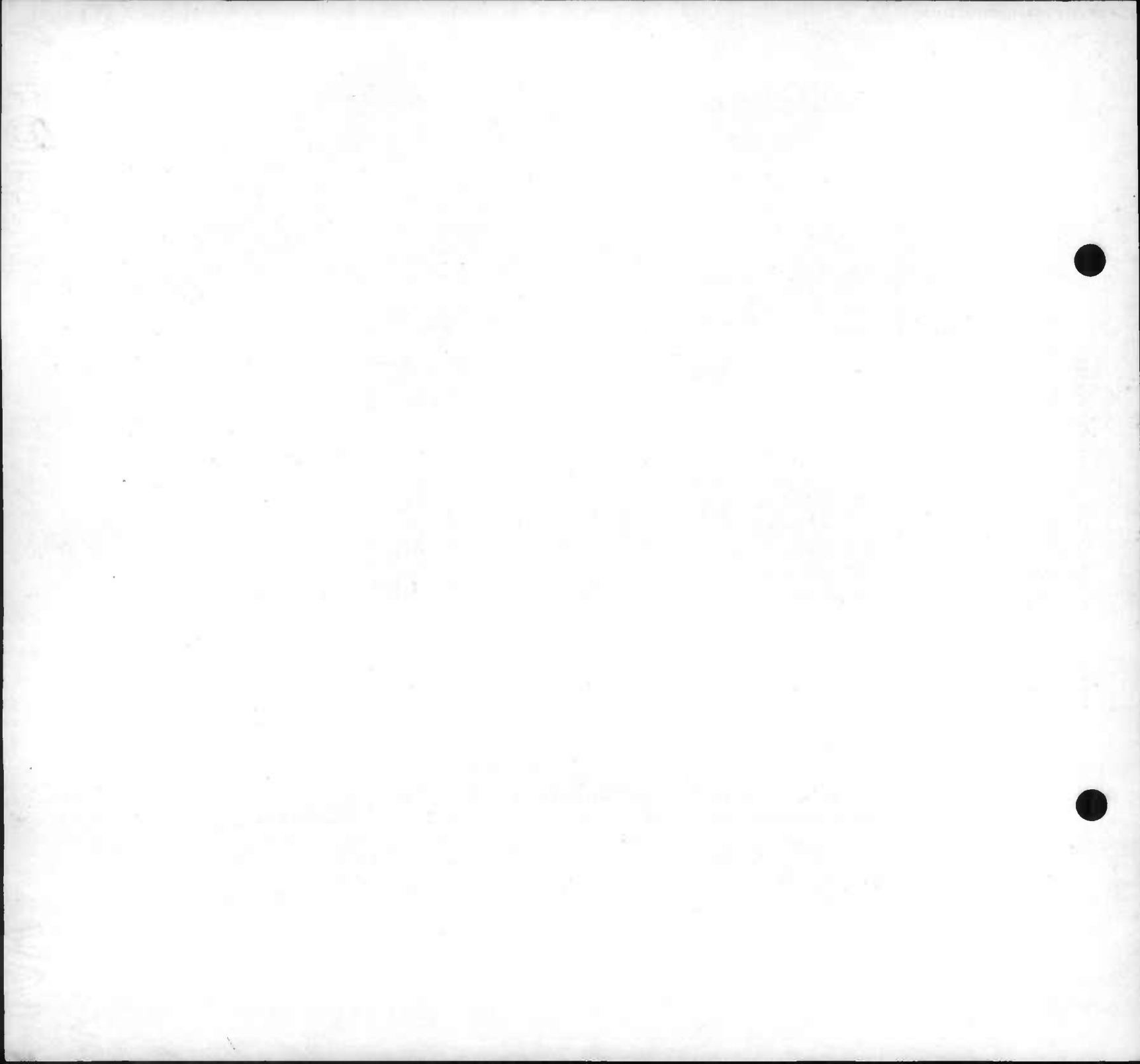
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68- 3535</u>	
BIRTH NO. <u>H-623</u>		68- 3535	
1. NAME OF DECEASED (Type or Print) <u>GATTIS V. HAIRSTON</u>		2. DATE AND HOUR OF DEATH <u>3-21-68</u> <u>7:40 PM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSP</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>820 DRUID HILL AVE</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-14-08</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>60</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>AMES HAIRSTON</u>		14. MOTHER'S MAIDEN NAME <u>ALICE DAY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FRIEND</u>		ADDRESS <u>—</u>	
18. <u>441.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>RUPTURED ABDOM. ANEURYSM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
19. <u>451X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>		20. <u>—</u>	
19A. DATE OF OPERATION <u>3-17-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ANEURYSM</u>	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (1) (this hospital) attended the deceased from <u>3-10</u> 19 <u>68</u> to <u>3-21</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>3-21</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>GARY L. NOBEL</u>		23B. DATE SIGNED <u>3-21-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>3/28/68</u>		24B. DATE <u>3/28/68</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>—</u>		24D. LOCATION (City, town, or county) (State) <u>—</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS <u>—</u>	



L-300

68-3536

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3536

BIRTH NO.

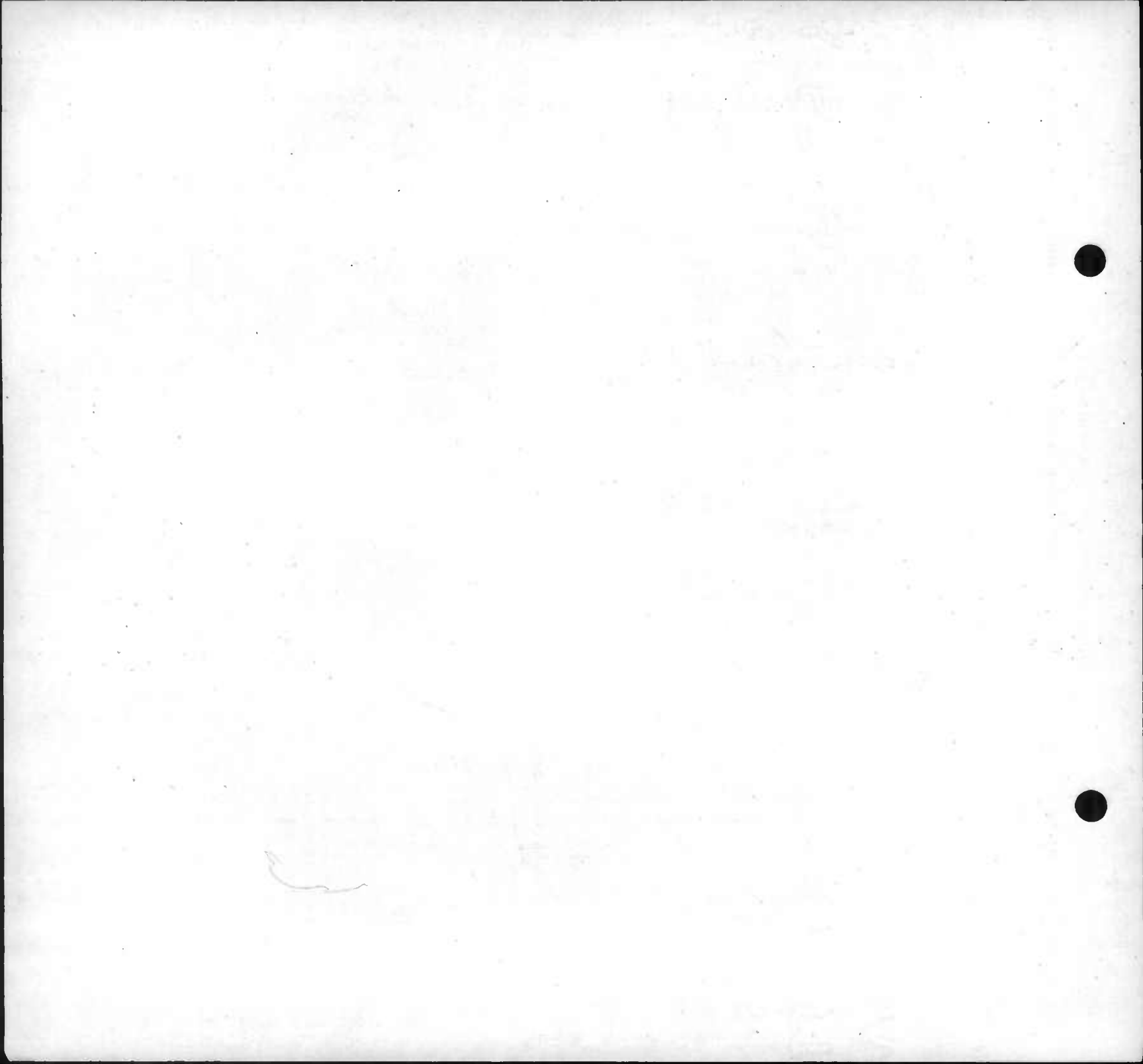
1. NAME OF DECEASED (Type or Print) <b>MILDRED LLOYD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>March 26, 1968</b>		Hour <b>5:10 A.M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1720 St. Paul Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 26, 1968</b>		Hour <b>5:10 A.M.</b>
6. SEX <b>female</b>		7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>43</b>	11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.
18. INFORMANT		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chirrhosis of Liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3/26/68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4/1/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>
24D. LOCATION (City, town, county) (State)		24E. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		24F. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

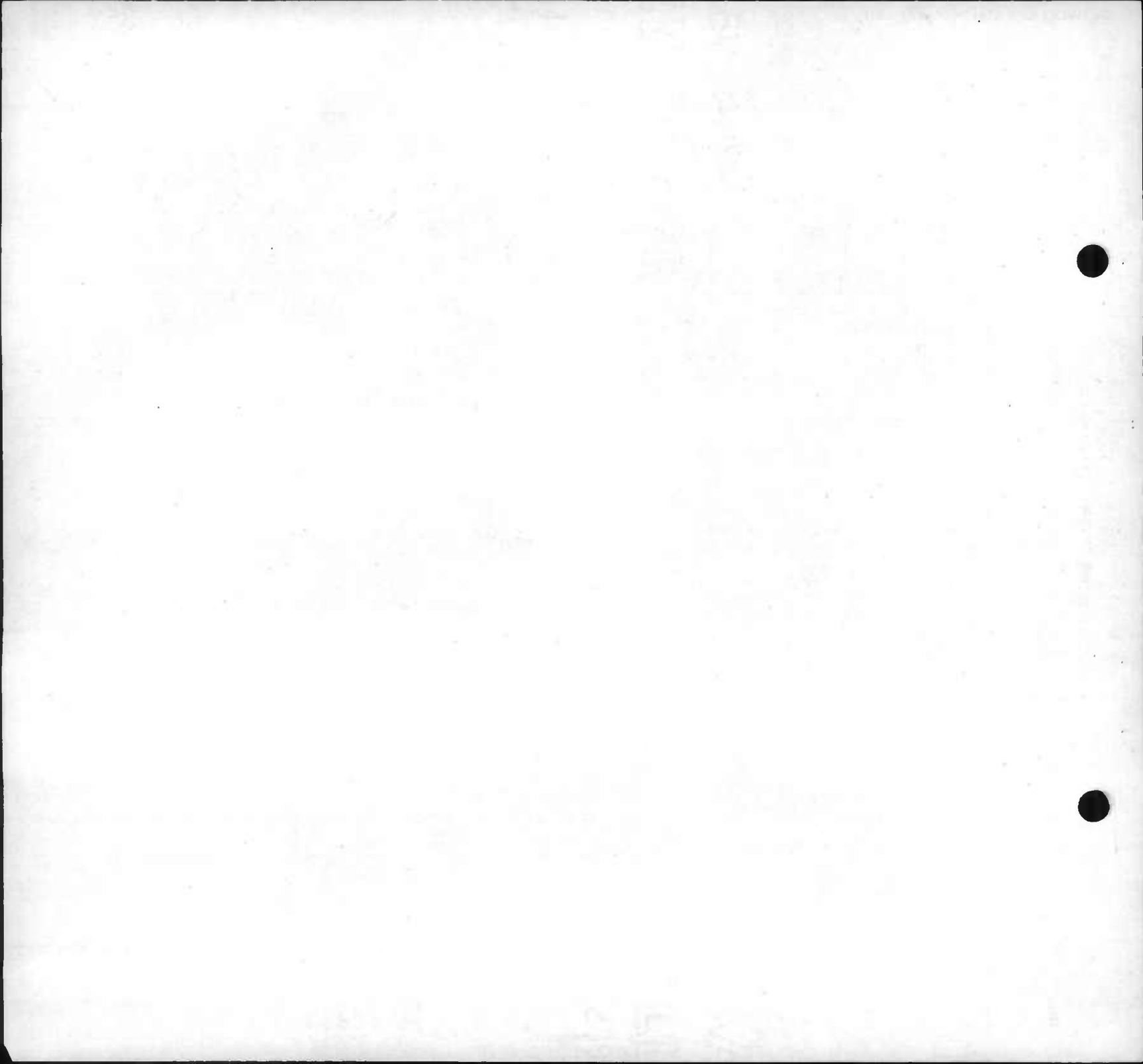
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 3537</b>	
R-300		68- 3537		CERTIFICATE OF DEATH	
BIRTH NO. <b>68-05763</b>		1. NAME OF DECEASED (Type or Print) <b>Baby Boy Reed (A)</b>			
2. DATE AND HOUR OF DEATH <b>March 19, 1968 2:00 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>University of Maryland Hospital</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2211 Asquith St. #18</b>	
5. SEX <b>Male</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1968</b>	9. AGE (In years last birthday) <b>9</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Melvin Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Reed</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lucinda Reed</b>	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>IMMATUREITY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>776X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs. 45 min.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 19 1968</b> to <b>March 19 1968</b> , that (I) (we) last saw the deceased alive on <b>2:00 PM March 19 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Shih-Wen Huang</b>				23B. DATE SIGNED <b>March 19, '68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SHIH-WEN HUANG</b>				23D. ADDRESS <b>University of Maryland Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/27/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>O. L. &amp; P. F. ...</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

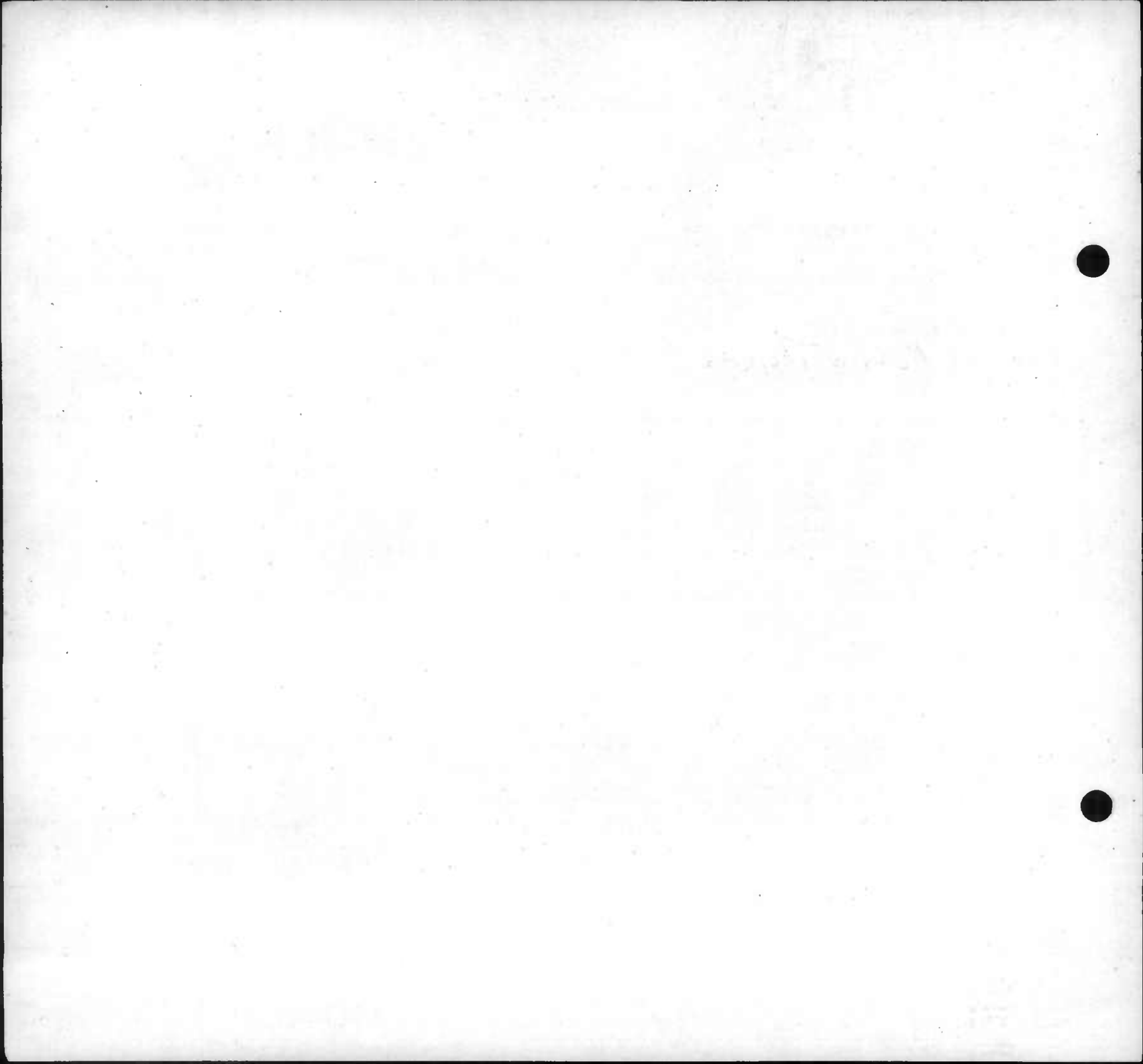
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3538</u>
<b>BIRTH NO.</b> <u>W-420 68-04673</u>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <u>BABY GIRL WILLIS</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>3-21-68</u> <u>4:55 P.M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>-</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>1819 REGISTER ST. 21213</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>N</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-13-68</u>	<b>9. AGE</b> (In years last birthday) <u>0</u> <b>10. Under 1 Yr.</b> Months: <u>8</u> Days: <u>8</u> <b>11. Under 24 Hrs.</b> Hours: <u>8</u> Min. <u>0</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>-</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>JOSEPH CARTER</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>PATRICIA WILLIS</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT ADDRESS</b> <u>HOSPITAL CHART</u>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>757.91</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>756.2 II</u> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>ARTHR O GYPOSIS MULTIPLEX CONGENITA</u> <u>ABO INCOMPATIBILITY</u> <u>PREMATURITY</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>7 DAYS</u> <u>BIRTH</u>		
<b>19A. DATE OF OPERATION</b> <u>3-15-68</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>JEJUNAL ATRESIA</u>		<b>20A. AUTOPSY? (Yes or No)</b> <u>YES</u>
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>NO</u>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>-</u>		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b> <u>-</u>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>3-13</u> <u>19 68</u> <b>to</b> <u>3-21</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>3-21</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
<b>23A. SIGNATURE</b> <u>Joseph Boyd</u>		<b>23B. DATE SIGNED</b> <u>3-21-68</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>-</u>
<b>23D. ADDRESS</b> <u>ANATOMY BOARD OF MARYLAND</u>		<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>3/27/68</u>		
<b>24B. DATE</b> <u>3/27/68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		
<b>24D. LOCATION</b> (City, town, or county) (State) <u>-</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>APR 2 1968</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fairley, M.D.</u>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <u>MORTUARY SERVICE - BCMD</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3539</u>
R-300		68-3539		CERTIFICATE OF DEATH
BIRTH NO. <u>68-05764</u>		1. NAME OF DECEASED (Type or Print) <u>Baby Girl Reed (B)</u>		
2. DATE AND HOUR OF DEATH <u>1:45 PM March 19, 1968</u>		M. <u>9-08</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore, Maryland</u> C. CITY OR TOWN <u>Baltimore</u> E. STREET AND NUMBER <u>2211 Asquith St.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Female</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1968</u>	9. AGE (In years last birthday) <u>9</u> <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>MELVIN THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Reed</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lucinda Reed</u>
18. <u>777 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>776 X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs. &amp; 15 min</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(A)</del> (this hospital) attended the deceased from <u>March 19, 1968</u> to <u>March 19, 1968</u> , that <del>(A)</del> (we) last saw the deceased alive on <u>PM March 19, 1968</u> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(A)</del> (We) (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>Shih-Wen Huang</u>				23B. DATE SIGNED <u>March 19, 1968</u>
23C. PHYSICIAN'S NAME (Type) <u>SHIH-WEN HUANG</u>		23D. ADDRESS <u>University of Maryland Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3/27/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert J. Johnson</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

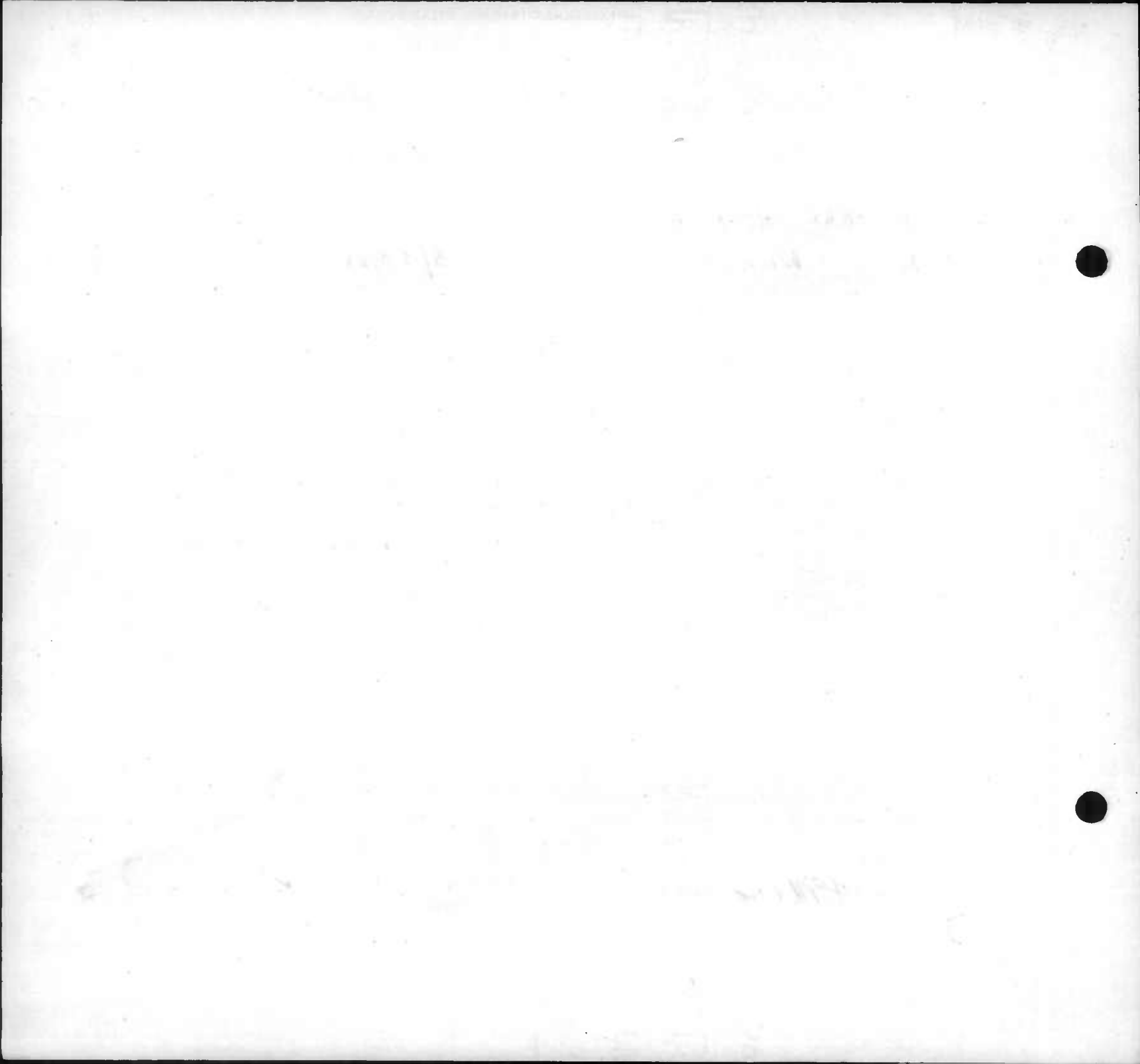
D-120 68- 3540		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3540	4
BIRTH NO. 68-05440			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>BABY BOY DAVIS</b>			2. DATE AND HOUR OF DEATH <b>3/24/68</b> 3:55 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE _____ B. COUNTY _____		
			C. CITY OR TOWN <b>Washington D.C.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>5006 Arkansas Ave</b>		<b>-48</b>
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/68</b>	9. AGE (In years last birthday) <b>8</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>35</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Dennis R. Davis</b>			14. MOTHER'S MAIDEN NAME <b>Vivian Yvonne Graves</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>chunt</b>	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prematurity</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
18. <b>776X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/24/68</b> 19 to <b>3/24/68</b> 19, that (I) (we) last saw the deceased alive on <b>3/24/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. S. Peroma</b>			23B. DATE SIGNED <b>3/34/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>F. S. Peroma, MD</b>			23D. ADDRESS <b>Lutheran Hospital &amp; Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>3/27/68</b>		24C. NAME OF CEMETERY <b>JOHNS HOPKINS MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>John E. Jackson</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

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CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3541 4</span>
C-623		68- 3541		CERTIFICATE OF DEATH
BIRTH NO. <u>68-05444</u>		1. NAME OF DECEASED (Type or Print) <u>BABY BOY CHRISTIAN</u>		
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Bolton</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL</u>		C. CITY OR TOWN <u>Bolton</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>20-02</u>
E. STREET AND NUMBER <u>2518 Lauretta Ave</u>		5. DATE OF BIRTH <u>3/23/68</u>		
6. SEX <u>M</u>	7. RACE <u>Negro</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>1</u>	If Under 1 Yr. Months <u>1</u> Days <u>6</u> If Under 24 Hrs. Hours <u>1</u> Min. <u>6</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Douglas Christian</u>		
14. MOTHER'S MAIDEN NAME <u>Ruth Thomas</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>chart</u>		
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. <u>776X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>F. Peroma</u>		23B. DATE SIGNED <u>3/23/68</u>		23C. PHYSICIAN'S NAME (Type) <u>F. Peroma, M.D.</u>
23D. ADDRESS <u>Johns Hopkins Hospital of Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify)		
24B. DATE <u>3/27/68</u>		24C. NAME OF CEMETERY OR CREMATORIAL <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>		
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>		
25B. NAME OF REGISTRAR <u>G. E. B. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3542 CERTIFICATE OF DEATH

REG. NO. 68- 3542

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Louisa W. Penn</u>		2. DATE AND HOUR OF DEATH <u>March, 27<sup>th</sup> 1968 4:20</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>2760 W. Lafayette Ave.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 20, 1891</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Germans Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>William Von Nettern</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Grempler</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01/3092</u>		17. INFORMANT ADDRESS	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>years</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>334X II</u>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March, 17<sup>th</sup> 1968</u> to <u>March, 27<sup>th</sup> 1968</u> , that (I) (we) last saw the deceased alive on <u>March, 27<sup>th</sup> 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael E. W. Yen</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>March, 27<sup>th</sup> 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael Yen</u>		23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3/30/1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>PROVIDENCE CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>DAYTON, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>	
25C. FUNERAL DIRECTOR <u>Easton Funeral Home</u>		ADDRESS <u>CATONSVILLE, MD.</u>			

APR 2 1968



W-2512

68- 3543

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3543

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WASHINGTON, EUGENE</b>		2. DATE AND HOUR OF DEATH <b>29 MARCH 68 1237</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>D C</b> B. COUNTY <b>DISTRICT OF COLUMBIA</b> C. CITY OR TOWN <b>WASHINGTON</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3920 AMES STREET</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-36</b>	9. AGE (In years last birthday) <b>31</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U S Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>EUGENE WASHINGTON</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE MYERS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNK</b>		17. INFORMANT <b>Eugene L. Washington</b> ADDRESS <b>Washington, DC</b>	
18. <b>253x2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>272X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL INFARCTION 5 DAYS</b> (B) <b>CEREBRAL VASOSPASM 5 DAYS</b> (C) <b>CHROMOPHOBIC ADENOMA 10 YEARS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>15 FEB 25</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHROMOPHOBIC ADENOMA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12 FEB 19 68</b> to <b>29 MARCH 19 68</b> , that (I) (we) last saw the deceased alive on <b>29 MARCH 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Merwyn Bagan</b>				23B. DATE SIGNED <b>29 MARCH 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MERWYN BAGAN</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Tabor Church Cemetery Shumansville, Va. 22550</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Ischura</b>		25C. FUNERAL DIRECTOR <b>W EDWARDS Funeral Home</b> ADDRESS <b>Bowling Green, Va.</b>	

THE UNIVERSITY OF

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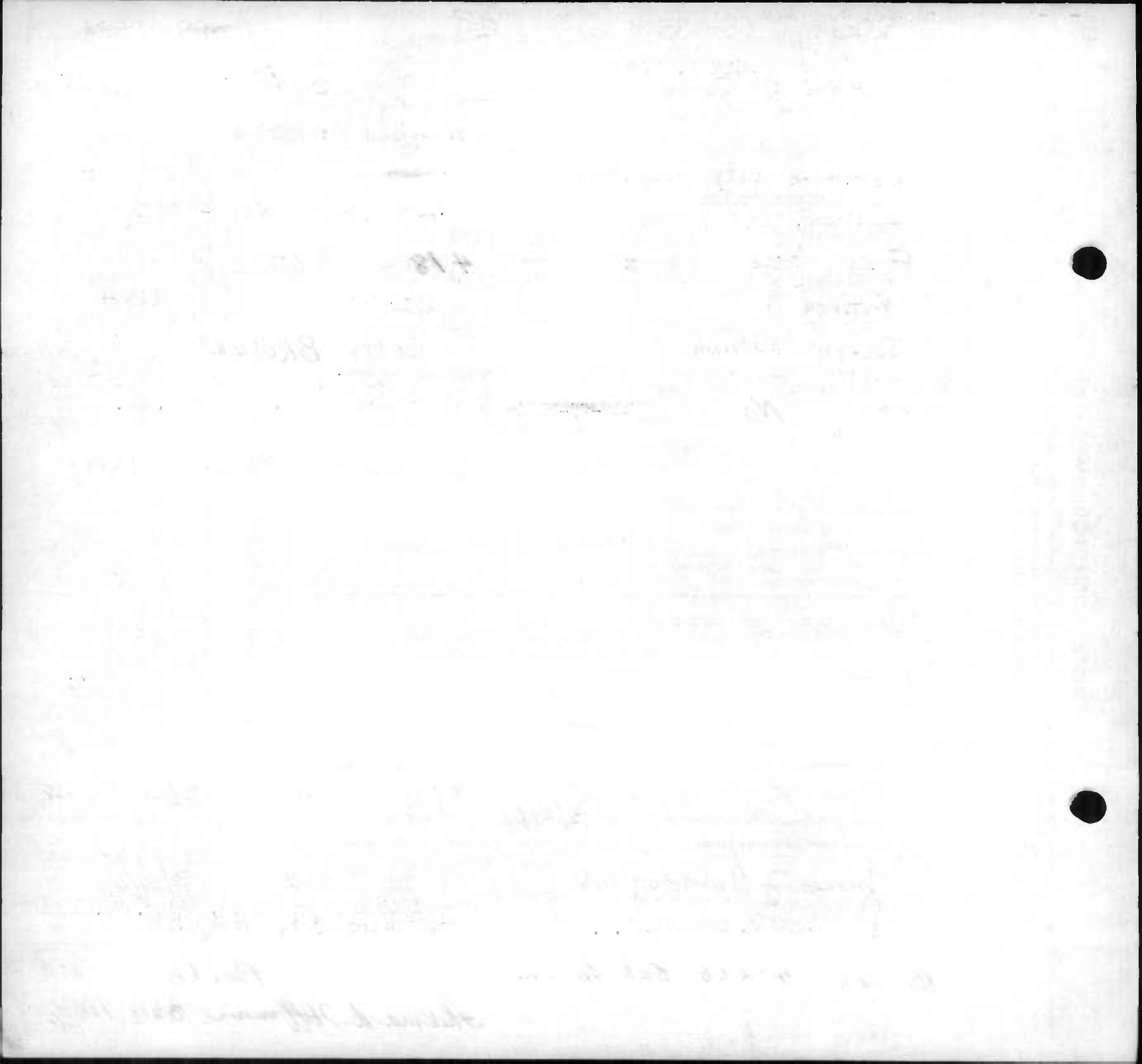
1875

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-500 68-3544				CITY HEALTH DEPARTMENT		REG. NO. 68-3544	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		ANNA D. JANNE Anna D. Janne		2. DATE AND HOUR OF DEATH 3/29/68 12 35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland. Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Baltimore City Hospitals		4940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER 1647 Poles Rd. - 21221			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/00	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Joseph Putnam				14. MOTHER'S MAIDEN NAME Betty BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown No		16. SOCIAL SECURITY NO. 218-05-9184-D		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
18. 1820 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma - endometrium (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
172X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 3/27/1968 to 3/29/1968, that (I) (we) last saw the deceased alive on 3/29/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James J. Tabasso, M.D.				23B. DATE SIGNED 3/29/68			
23C. PHYSICIAN'S NAME (Type) JAMES J. TABASSO, M.D.				23D. ADDRESS 940 Eastern Avenue, Balto., Md. 21224 Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-68		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Shelma D. Hoffmann 3218 Hudson St.			



L-320

68- 3545

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3545

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SUEANN D. LITZ</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> Hour <b>4:15 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR IN INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1903 Sheerwood Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 29, 1968 4:15 P.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>June 15, 1950</b>		10. AGE (In years last birthday) <b>17</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Kreiner</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Elizabeth Egan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>John Kreiner 5523 Ashbourne Rd.</b>	
19. <b>E 965 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of the head</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E 981 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Gunshot wound of the head</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1903 Sheerwood Avenue 9-08</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour P.M. <b>3 29 68 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Subj. was shot and raped.</b>		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-30-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. J...</b>	
25C. FUNERAL DIRECTOR <b>Dumbur, Inc. 1321 Sulphur Sp. Rd.</b>		ADDRESS	

WALTER D. JOHNSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
5-320		68- 3546		CERTIFICATE OF DEATH		REG. NO. 68- 3546			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		SADOWSKI, JOHN A				MARCH 27, 1968 4:10P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
40		ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				MARYLAND		BALTIMORE	
5. SEX						6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE						WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH						9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
06/24/87						81		U S A	
11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?			
MARYLAND						U S A			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT	
						215017109		CATON & WILKENS AVE. BALTO MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
156.0 I						CARCINOMA, GALL BLADDER		?	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES						(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) DUE TO, OR AS A CONSEQUENCE OF:			
155.1 II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3/16/68		CA, GALL BLADDER		No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
No									
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from MARCH 14 19 68 to MARCH 27 19 68, that (X) (we) last saw the deceased alive on MARCH 27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
W. E. Signor M.D.						3/29/68			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
DR SIGNOR						BALTO MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3-30-68		Sacred Heart Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 2 1968		W. E. Signor		Walter Dabrowski		1005 Dundalk Avenue			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">68- 3547</span>	
M-246 <span style="margin-left: 50px;">68- 3547</span> <span style="float: right;">CERTIFICATE OF DEATH</span>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Anna M. McClure</span>			
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 1, 1968</span>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">622 West 36th Street Baltimore, Maryland 21211</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">Female</span>		6. RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov 17, 1880</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">87 yrs.</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">Vance</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">McCrosson</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-03-9941-D</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr. Charles S. McClure 622 W. 36th St. 21211</span>	
18. <span style="font-size: 1.2em;">4120 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cerebral Thrombosis</span> (B) <span style="font-size: 1.2em;">Hypertensive arteriosclerotic cardiovascular disease</span> (C) <span style="font-size: 1.2em;">Pernicious Anemia</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">11-23-67</span> <span style="font-size: 1.2em;">10 years</span> <span style="font-size: 1.2em;">4 years</span>	
19. <span style="font-size: 1.2em;">443X II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">None</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">19 50</span> to <span style="font-size: 1.2em;">Present</span> 19 <span style="font-size: 1.2em;">68</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">March 31</span> 19 <span style="font-size: 1.2em;">68</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <input checked="" type="checkbox"/> ) (did) ( <input checked="" type="checkbox"/> ) ( <input type="checkbox"/> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">W. H. Townshend, Jr.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">4-1-68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Wilfred H. Townshend, Jr., M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">14 E. Eager Street - Balto Md. 21202</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Apr 4, 1968</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Lorraine Park Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Woodlawn, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 2 1968</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Frank J. Lutz</span>			
ADDRESS <span style="font-size: 1.2em;">814 W 36 St 21211</span>					

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THE UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

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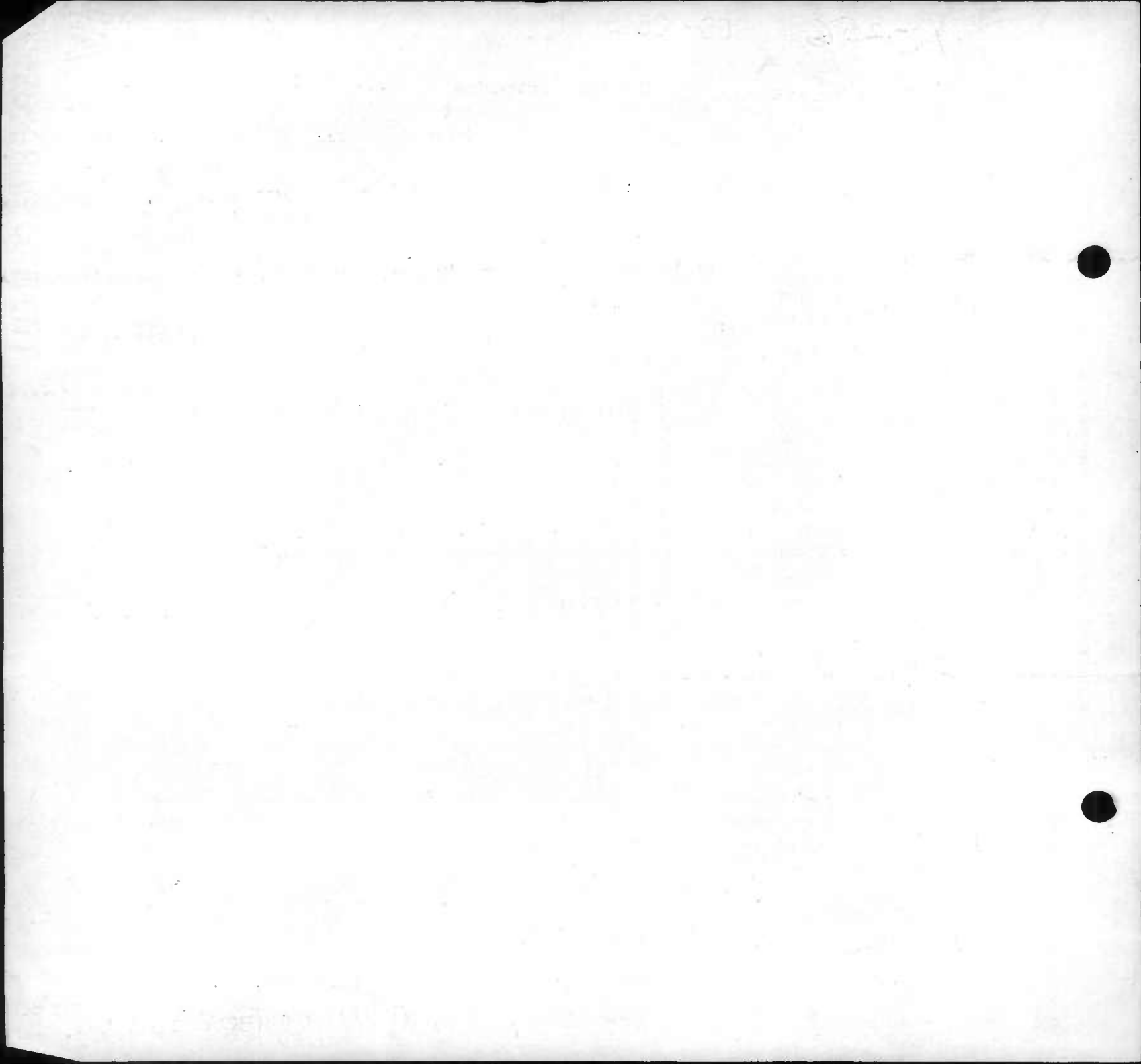
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-256		68-3548		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3548	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>KAZMERSKI, Katherine</b>			
2. DATE AND HOUR OF DEATH <b>3/30/68 - 10:50 AM</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>50. BALT GEN'L Hosp</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>XXXXXX</b> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>410 Hillcrest Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/02</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>Martha</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-0781</b>	
17. INFORMANT <b>Son - John Kazmerski</b>		ADDRESS <b>216 Meadow Rd</b>		18. <b>571.8 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19. <b>581.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>GI Hemorrhage</b>		(B) <b>Post Necrotic Cirrhosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b>	
19A. DATE OF OPERATION <b>3/28/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GI Bleeding</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>—</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>		22. I certify that <b>HT</b> (this hospital) attended the deceased from <b>3/28</b> 19 <b>68</b> to <b>3/30</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>3/30</b> 19 <b>68</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>HT</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Neil Novin</b>		23B. DATE SIGNED <b>3/30/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Neil Novin MD</b>		23D. ADDRESS <b>2 E. Read St BART</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>McCully &amp; 130 E. Fort Ave</b>		ADDRESS <b>21230</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-3549	
BIRTH NO. 17-400		68-3549					
1. NAME OF DECEASED (Type or Print) <u>Viola A. Muhl</u>				2. DATE AND HOUR OF DEATH <u>Mar. 30, 1968</u> <u>4:33</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hospital</u>				C. CITY OR TOWN <u>Lansdowne</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-6-1902</u> 9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Conrad Schultheis</u>				14. MOTHER'S MAIDEN NAME <u>Helena Miller</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-12-9562</u>		17. INFORMANT ADDRESS <u>Mr. Ferdinand A. Muhl, 910 Catawba Ct. 21227</u>	
18. <u>572.0 II</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PERITONITIS</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
<u>REGIONAL ENTERITIS</u>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PULMONARY EMPHYSEMA</u>							
19A. DATE OF OPERATION <u>3/25/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTESTINAL OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>3-24</u> 19 <u>68</u> to <u>3-30</u> 19 <u>68</u> , that (we) lost saw the deceased alive on <u>3-30</u> 19 <u>68</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gerard D. Dobrzycki MD</u>				23B. DATE SIGNED <u>3/30/68</u>		23C. PHYSICIAN'S NAME (Type) <u>GERARD D. DOBRZYCKI MD</u>	
23D. ADDRESS <u>South Balto. Gen. Hosp.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-3-1968</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25D. NAME OF REGISTRAR	

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3550</b>	
R-200 68-3550				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSS, GLENN M., Jr.</b>		2. DATE AND HOUR OF DEATH <b>3-29-68 5:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>Carroll Co. 56-00</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>HAMPSTEAD</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>8. CARROLL STREET. 126</b>	
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-20-17</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT OWNER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	
13. FATHER'S NAME <b>GLENN M. ROSS, JR.</b>		14. MOTHER'S MAIDEN NAME <b>J. DOROTHY DEYO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>212-05-3820</b>		17. INFORMANT ADDRESS <b>Dorothy Ross Carroll St. Hampstead, Md.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCD.</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>03-25-1968</b> to <b>03-29-1968</b> , that (I) (we) last saw the deceased alive on <b>03-29-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>DR. SARAVUT SRIEUNGFUNG, M.D.</b>				23B. DATE SIGNED <b>03-29-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARTIN L. SINGEWALD, M.D.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 1, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hampstead Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Hampstead Carroll Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>			

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68- 3551 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3551

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JESSIE E. NICHOLAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1968</b>		Hour <b>9:30 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 HOPKINS HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 30, 1968</b>		Hour <b>9:30 P.</b>
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>2/8/19</b>		10. AGE (In years last birthday) <b>49</b>		C. CITY OR TOWN <b>Baltimore</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		E. STREET AND NUMBER <b>4232 Evans Chapel Road</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>217-20-8840</b>		15. MOTHER'S MAIDEN NAME <b>ANNIE BUA KETT</b>
18. INFORMANT <b>L.A. Nicholas</b>		ADDRESS <b>4232 EVANS CHAPEL RD</b>		
19. <b>E 950.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Overdose of Phenobarbital</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4232 Evans Chapel Road</b>
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>3 30 68 11:30 a</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Ingested overdose of Phenobarbital</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Roland N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Roland N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-31-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbiter's Mem. PK</b>
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Wm. J. Chaturang</b>		
25D. ADDRESS <b>1701 M. C. Culloh St.</b>				

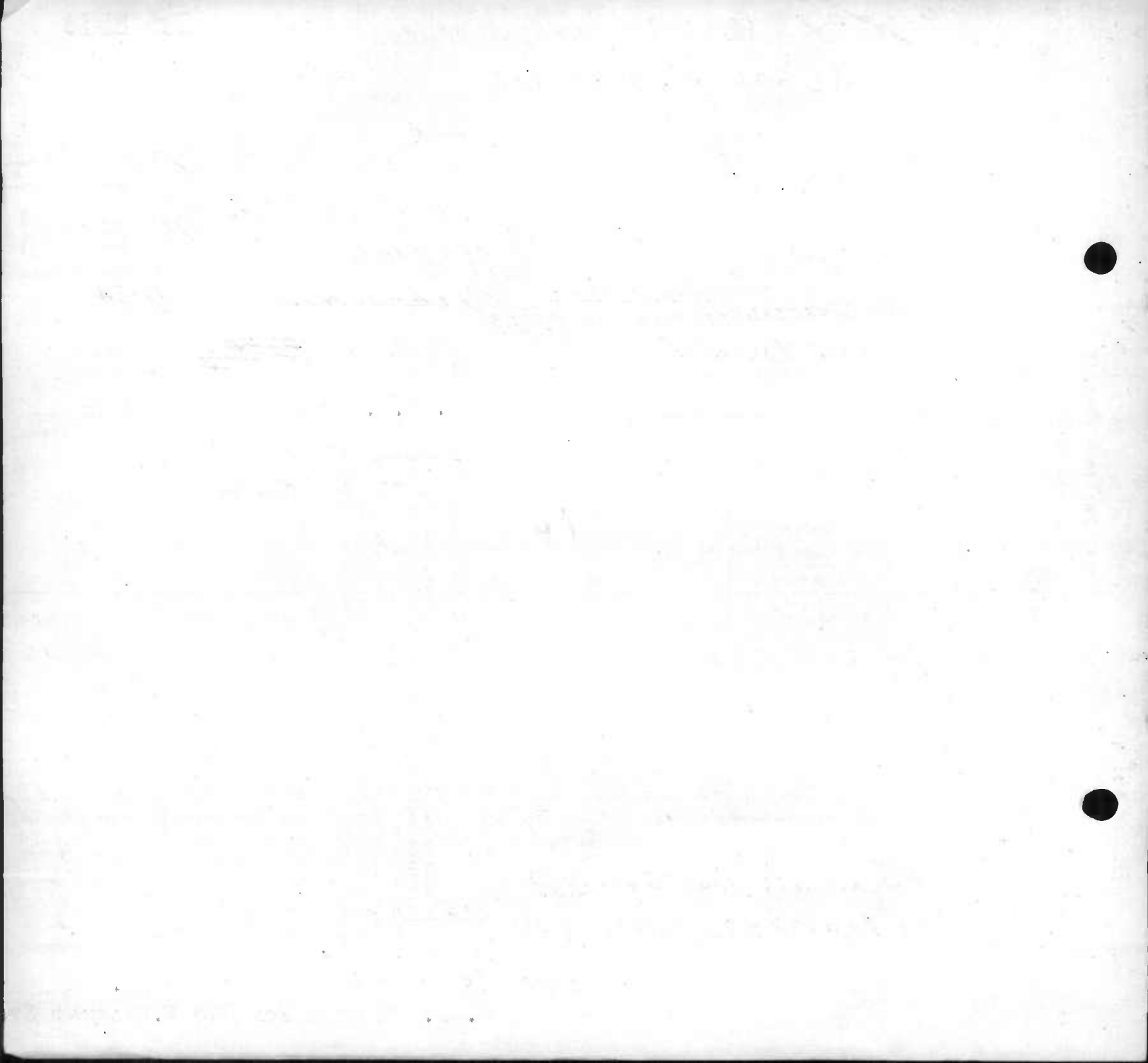
WALTON & PORTER

*[Faint signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				B-623 68-3552		CERTIFICATE OF DEATH		WED. NO. 68-3552	
1. NAME OF DECEASED (Type or Print) <b>ALSON A BRISTOL</b>				2. DATE AND HOUR OF DEATH <b>3/31/68 7:30 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home &amp; Hosp 35</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hosp 35</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>				6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>9/30/06</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INTERNATIONAL UNION OFFICIAL PRINTING PRESSMAN</b>				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>61</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>Nebraska</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ellis Bristol</b>			
14. MOTHER'S MAIDEN NAME <b>Alma Price</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. A.A. BRISTOL MADISON APTS</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the Lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>metastasis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>16</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>68</b> to <b>3/31</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Francisco Baltazar Jr MD</b>				23B. DATE SIGNED <b>3/31/68</b>				23C. PHYSICIAN'S NAME (Type) <b>FRANCISCO BALTAZAR JR MD</b>	
23D. ADDRESS <b>Church Home &amp; Hosp BALTO 31, MD</b>				23E. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON 805 N. CALVERT ST.</b>		23F. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>4/1/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>GREENMOUNT CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>				25C. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON 805 N. CALVERT ST.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
T-200		68- 3553		68- 3553
<b>CERTIFICATE OF DEATH</b>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		ELLA TAWES		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
UNION MEMORIAL HOSP.		MARYLAND		
15. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH (lost birthday)
Seafood Packer		White Seafood		05/5/34 P3
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years)
SAMUEL WEBSTER		XXXXXXXXXX Druscilla Webster		83
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTH PLACE (State or foreign country)
		219-14-4248		Deals Island
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?
DAVID HORNER		6406 ALTA AVE.		USA
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4/36.9 + 1250.9		CVA		12 days
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DIABETES MELLITUS		
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				No.
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/19 1968 to 4/1 1968, that (I) (we) last saw the deceased alive on March 31/19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Enrique Cipriani M.D.		4/1/68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
ENRIQUE CIPRIANI, M.D.		THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		4/3/68		St. John's Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
APR 2 1968		Schimunek Funeral Home, Inc.		ADDRESS
				3331 Brehms Lane

ELLER T H 112

MARYLAND

BALTIMORE

X

UNION MEMORIAL HOSP. 6704 ALTA AVE.

02/2/84 63

F W X

U 20

MARYLAND

UNK. WK.

SAMUEL WEBSTER

ALTA AVE. 6704

DAVID ROYER

C V R

DIABETES MELLITUS

NO.

March 31 1984

EMERGENCY  
CHIEF, M.D. 335 and Cabinet

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 3554</b>
BIRTH NO. <b>B-630</b>		68- 3554 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>RAPHAEL J. BARRETT</b>		2. DATE AND HOUR OF DEATH <b>MARCH 31, 1968 10<sup>20</sup> a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>3739 LYNDALE AVENUE</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 23, 1909</b>	9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Continental Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>
13. FATHER'S NAME <b>MICHAEL BARRETT</b>		14. MOTHER'S MAIDEN NAME <b>CHARLOTTE LOTTIE JACKSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>25-03-383</b>		17. INFORMANT ADDRESS <b>Leo J. Barrett, 5107 Frankford Ave.</b>
18. <b>600 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>210 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>Ch. Gen</b>
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>3-28-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostatectomy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 22 1968</b> to <b>MARCH 31 1968</b> , that (I) (we) last saw the deceased alive on <b>MARCH 31 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Nieva G. Valle</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>MARCH 31, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>NIEVA G. VALLE</b>		23D. ADDRESS THE UNION MEMORIAL HOSPITAL <b>UNION MEMORIAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/4/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>

WEDNESDAY

MARYLAND

BALTIMORE

8339 LYNDALE AVENUE

WHITE MEMORIAL HOSPITAL  
BALTIMORE, MARYLAND

OCT 22 1960

M W

MARYLAND

ESTIMED

LOTTIE JACKSON

MICHAEL BARRETT

247-02 382

423

3-28-62 Registration

MARCH 22 1962

MARCH 21 - 62

*Handwritten signature*

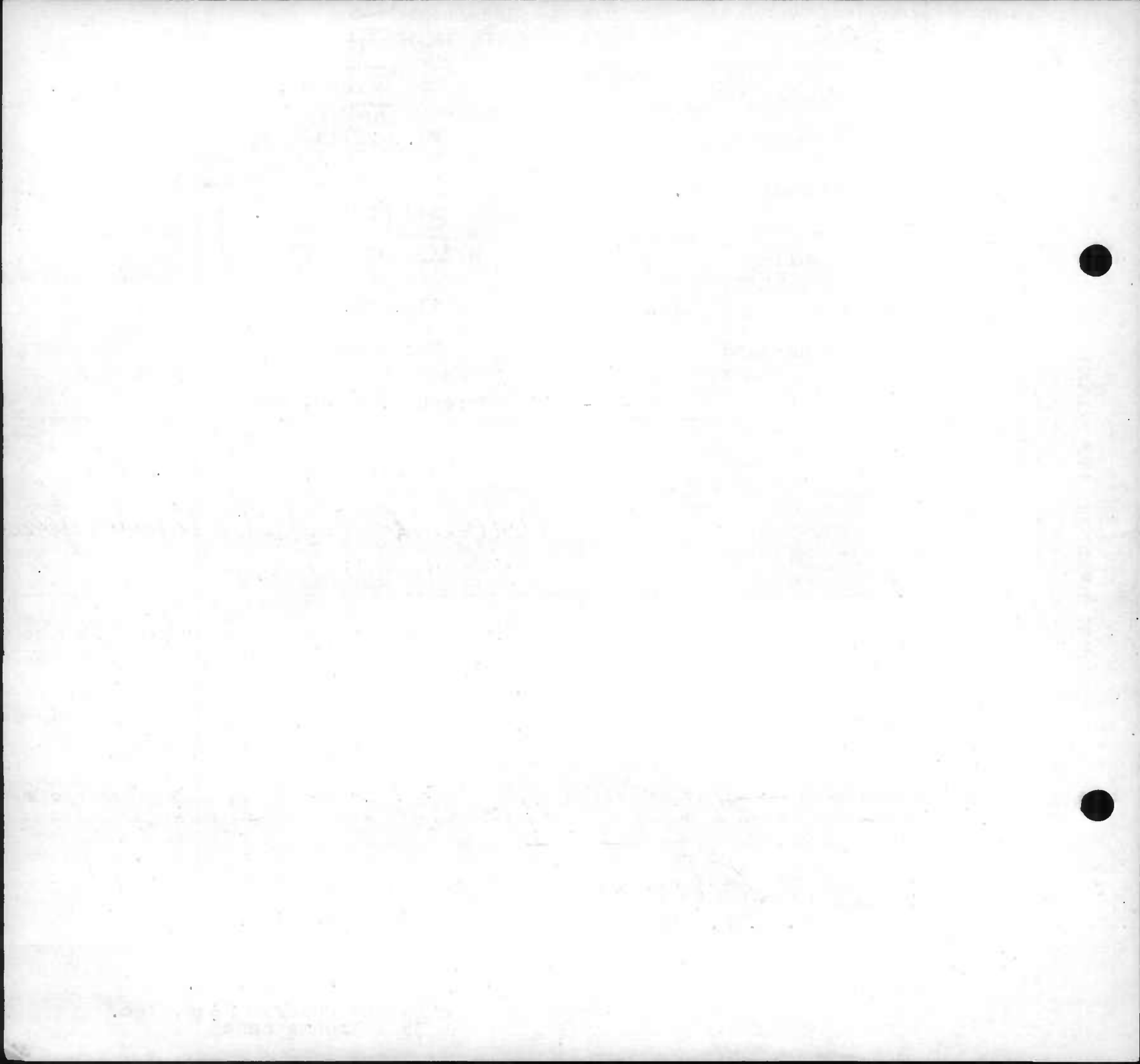
NICOLA G. VALLE

UNION MEMORIAL HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3555</u>
R-300		68-3555		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
CHARLES FRANCIS READ		March 30, 1968 7:45 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  3619 Dudley Ave.		A. STATE Md., 21213		
		B. COUNTY Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3619 Dudley Ave.				
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1892	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Stewart's		11. BIRTHPLACE (State or foreign country) Phila. Pa.
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Frank Read		14. MOTHER'S MAIDEN NAME Mary Brenneman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-01-8392		17. INFORMANT Joseph F. Read, son, above
18. <u>4/10/0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Thrombosis</u> (B) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u> (C) <u>Has been a paralytic 10 yrs.</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19. DATE OF OPERATION <u>4/20/1</u> II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>4/20/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/2</u> 19 <u>67</u> to <u>3/30</u> 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>3/13</u> 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <u>L. B. Stevens</u>		23B. DATE SIGNED <u>4/1/68</u>		
23C. PHYSICIAN'S NAME (Type) Dr. L. B. Stevens		23D. ADDRESS 3400 Erdman Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/2/68		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery
24D. LOCATION Woodlawn, Md.				
25A. DATE REC'D BY HEALTH DEPT. APR 2 1968		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane
25D. ADDRESS				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>PAUL PETRI JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>March 30, 1968</b>		Hour <b>5:10 A</b> M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 30, 1968</b>		Hour <b>5:10 A</b> M.
6. SEX <b>Male</b>		7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Dec. 10, 1903</b>		10. AGE (in years lost birthday) <b>64</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Paul Petri, Sr.</b>		14. USUAL OCCUPATION (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY
15. MOTHER'S MAIDEN NAME <b>unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>212-07-9834</b>
18. INFORMANT <b>Mary Ann Struck Petri, wife, above</b>		19. CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>4/22/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-30-68</b>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>

WALTER  
Gus Miller

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68- 3557</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>F-600</b></span> <span><b>68- 3557</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY FREYE</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>March 27, 1968</b> <b>6:30 a.</b> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Ventnor Lodge Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md., 21206</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3910 Walnut Avenue</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/1882</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Conrad Binau</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hamilton</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-01-6242D</b>		17. INFORMANT <b>Keneth J. Freye, son, above</b>	
18. <b>440.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Terminal pneumonia</b> (B) <b>A.S.D. Chronic Brain syndrome</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>450.0 II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> to <b>March 27 1968</b> , that (I) (we) lost saw the deceased alive on <b>March 27 1967</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Samuel M. Alagia</b>				23B. DATE SIGNED <b>3/27/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. D. P. Alagia</b>				23D. ADDRESS <b>3326 Frederick Avenue</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>3331 Brehms Lane</b>					

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3558

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SEAMON, HELEN F.

2. DATE AND HOUR OF DEATH

3-28-68

4:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)BALTIMORE CITY HOSPITALS  
4940 EASTERN AVENUE  
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5104 LODESTONE WAY #21206

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

4-11-06

9. AGE (In years  
last birthday)

61

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Cleveland  
OHIO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Vozlov Flandera

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

081-28-9501

17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS

4940 EASTERN AVE., BALTO., MD. #21224

ADDRESS

18. 430.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) cerebral vas. aneurysm

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

40 hrs.

yrs.

MEDICAL CERTIFICATION

330X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/26/ 19 68 to 3/28 19 68  
that (I) (we) last saw the deceased alive on 3/28 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. M. Levinsohn, M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3-28-68

23C. PHYSICIAN'S  
NAME (Type)

E. M. LEVINSHOHN, M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE., BALTO., MD. #21224

24A. BURIAL CREMATION, 24B. DATE  
REMOVAL (Specify)

CREMATION

3/30/68

24C. NAME OF CEMETERY or CREMATORY

GREEN MOUNT CEMETERY

24D. LOCATION

(City, town, or county)

BALTIMORE MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 2 1968

25B. NAME OF REGISTRAR

Robert E. J...

25C. FUNERAL DIRECTOR

SCHIMMELER FUNERAL HOME  
3331 BRETHNS LA. BALTO MD.

ADDRESS

BALTO MD.


FUNERAL DIRECTOR: IMPORTANT

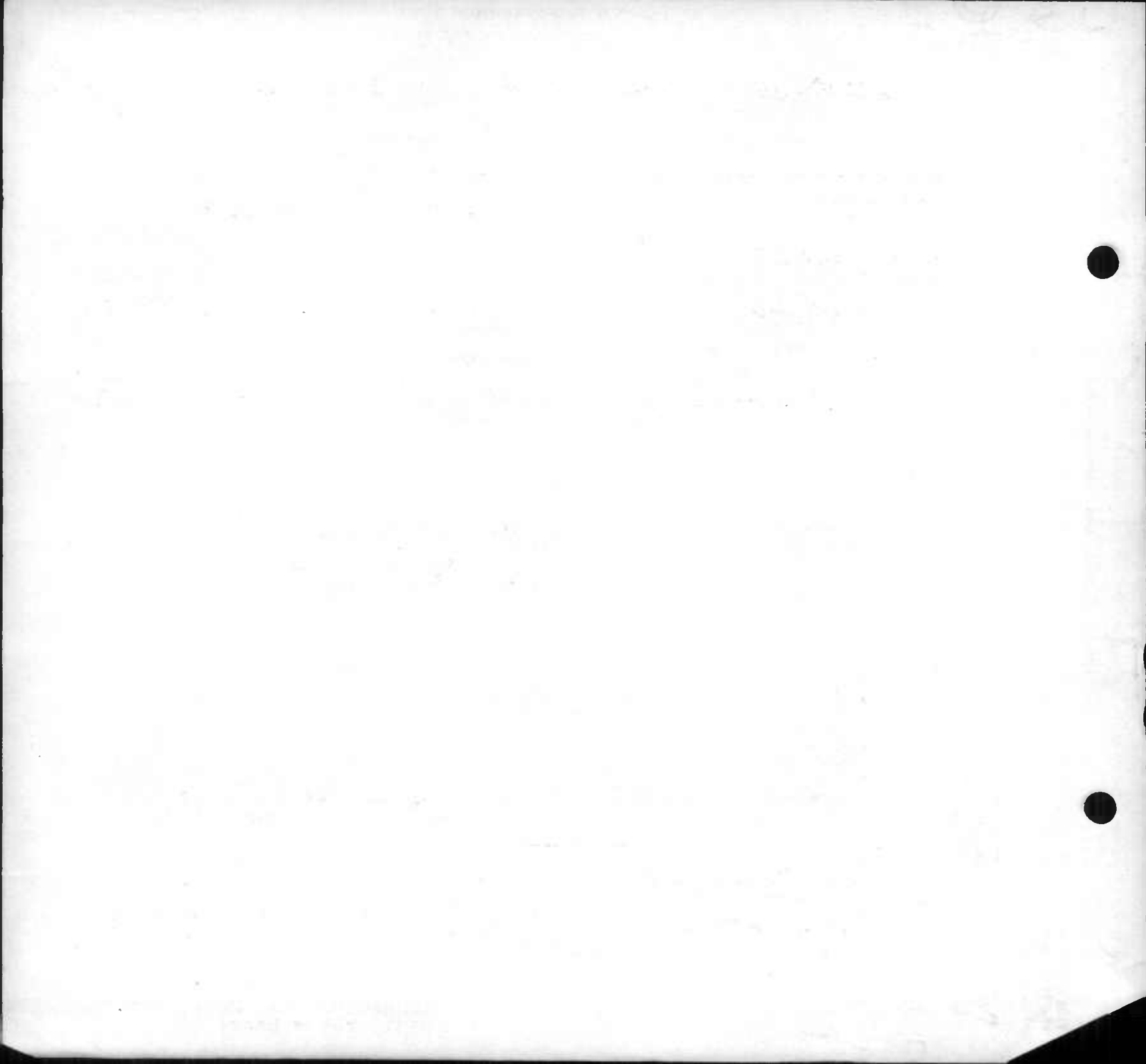
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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# FUNERAL DIRECTOR: IMPORTANT

certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG NO. 68-3559	
E-451 68-3559		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELLEN BERGER, LUDWIG, N.</b>		2. DATE AND HOUR OF DEATH <b>3-29-68 3 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26.02</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4603 CHADFORD AVE</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/1927</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Biol. Biological lab.</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>41</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Ellenberger</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Furlong</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Morean-1950-1952</b>		16. SOCIAL SECURITY NO. <b>214-20-5198</b>	
17. INFORMANT <b>Dolores Poggioli Ellenberger, wife</b>		ADDRESS above	
18. <b>427.2 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Heart failure</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Brain hypoxia</b>			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>Cerebral arrest</b>			
19. DATE OF OPERATION <b>3-19-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Peptic Ulcer</b>	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>3-16-1968</b> to <b>3-29-1968</b> , that (H) (we) last saw the deceased alive on <b>3-29-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED <b>3-29-1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>T. K. SATYA V. RITHAN</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL OF MARYLAND 730 Ashburton Street Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/1/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3560

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3560

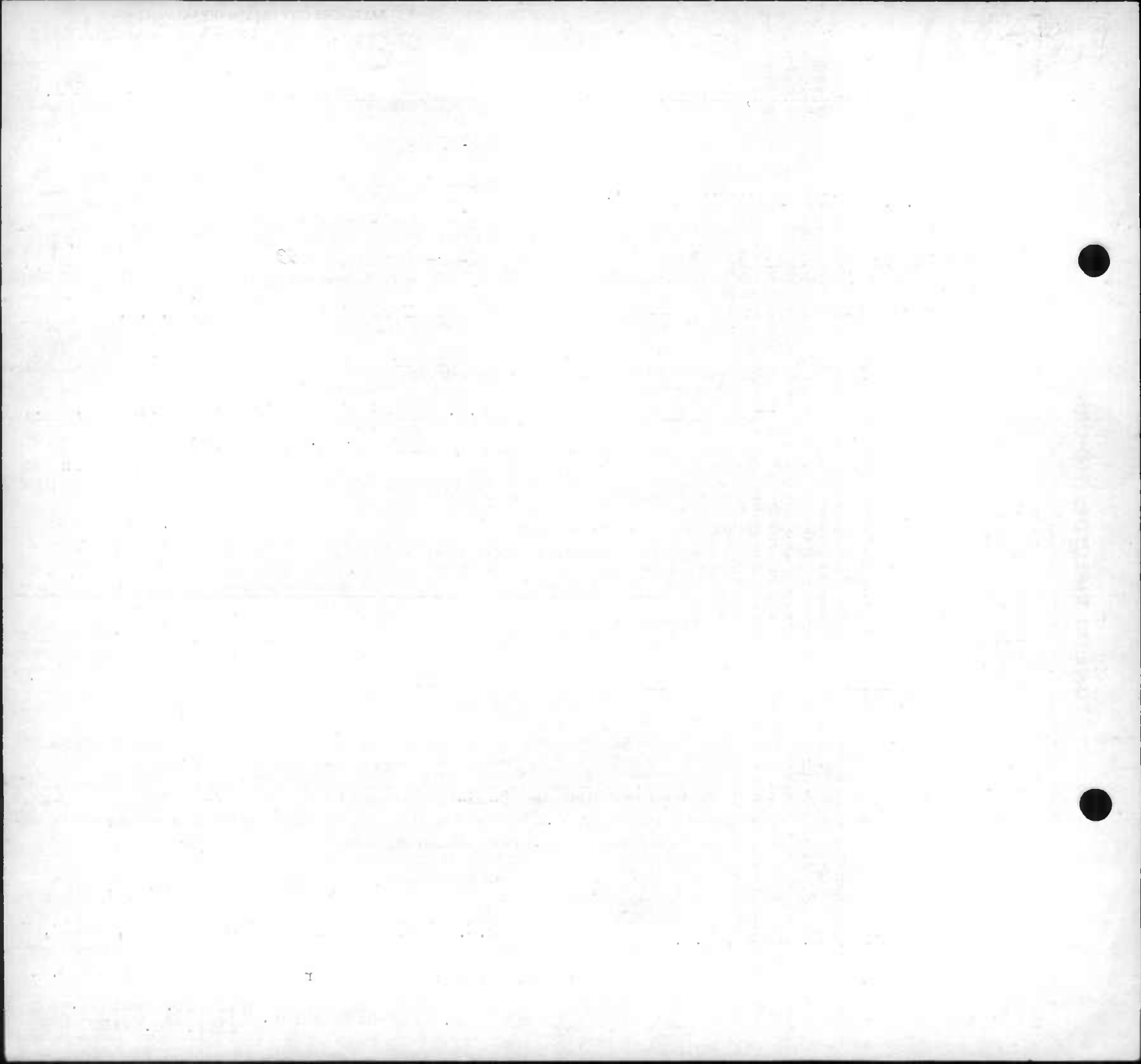
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Maitland, Mr. John S.</u>		2. DATE AND HOUR OF DEATH <u>March 31, 1968</u>   <u>10<sup>30</sup></u> <u>P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>700 W. 40th Street</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1910</u>	9. AGE (In years last birthday) <u>57 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice-Pres. Genl Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Kansas City Bridge Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Utah</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George F. Maitland</u>		14. MOTHER'S MAIDEN NAME <u>Una Sevier</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-09-6139</u>		17. INFORMANT ADDRESS <u>Keswick Records-Helen Leon R.N.</u>	
18. <u>712.3</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Rheumatic Arthritis</u> (B) <u>Chronic Brain Syndrome</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>1 yr.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>722.0 II</u>		Rheumatic Pleuritis			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/15/66</u> 19 - to <u>3/31</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <u>E. Hunter Wilson, M.D.</u>				23B. DATE SIGNED <u>4-1-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Hunter Wilson, M.D.</u>				23D. ADDRESS <u>700 W. 40th St. Balt. Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>4-2-68</u>			
25B. NAME OF REGISTRAR <u>Wm Cook-Branks</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Townson, Md.</u>			

Wm Cook & Sons  
London 4-2-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>68- 3561</u>
68- 3561 CERTIFICATE OF DEATH						
BIRTH NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH
			FLEISHMAN, Therese Kunigunda			April 1, 1968 2 A. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY			
U.S. PUBLIC HEALTH SERVICE HOSPITAL			Maryland Montgomery Co 65-00			
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
			Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER			
			1310 Dilston Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-13-14	33		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Secretary-housewife		---		New York		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?			
August Klotz			U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		N/A		U.S. PUBLIC Health Service Hosp., Balto, Md.		
18. <u>193.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Glioblastoma, multiforme (astrocytoma)  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months						
19. <u>193.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
				Yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
				No		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>3-11-68</u> 19 <u>68</u> to <u>4-1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 1</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Henry S. Crist, M.D.</u>				23B. DATE SIGNED April 1, 1968		
23C. PHYSICIAN'S NAME (Type) <u>Henry S. Crist, M.D.</u>				23D. ADDRESS <u>U.S. PUBLIC HEALTH SERVICE HOSPITAL, Balto, Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		
Burial		4/4/68		Long Island National Cemetery		
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)				
Farmingdale, Long Island N.Y.						
25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairburn</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Inc. 1217 St. Paul St. Balto. Md. 21202</u>		



FUNERAL DIRECTOR: IMPORTANT

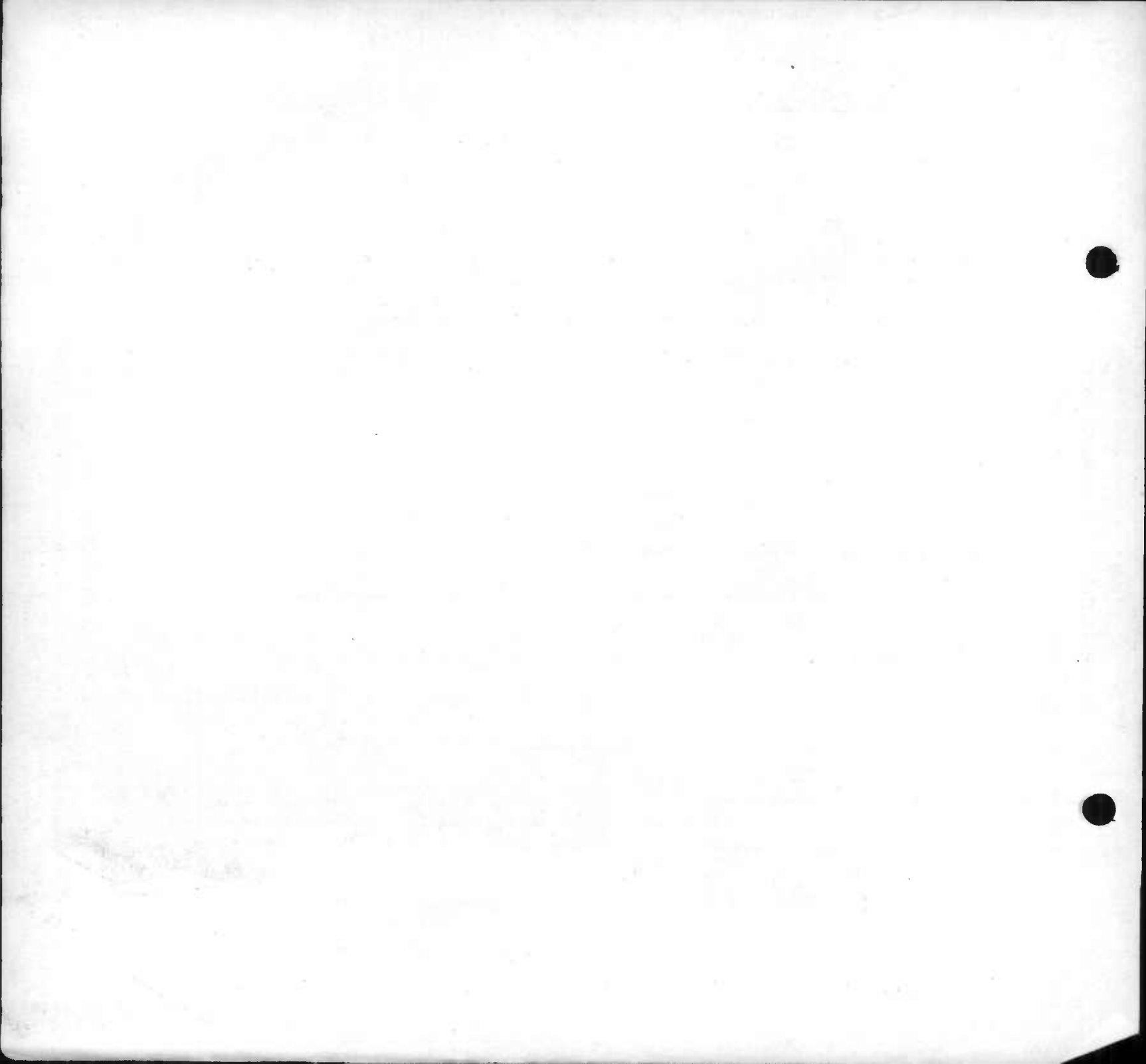
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3562

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3562

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NATHAN LAYMAN</b>		2. DATE AND HOUR OF DEATH <b>3-28-68 2:15 P. M.</b>	
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>		E. STREET AND NUMBER <b>516 W. FAYETTE ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-24-86</b>	9. AGE (In years lost birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balt. Transit Co</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GOTLEIB LAYMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET BAKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-10-0564-A</b>		17. INFORMANT ADDRESS	
18. <b>593.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA, 2° to KIDNEY INFARCTION AND URINARY TRACT INFECTION</b>		CAUSE OF DEATH <b>SEPTICEMIA, 2° to KIDNEY INFARCTION AND URINARY TRACT INFECTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>603X II</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-11-68</b> 19 to <b>3-28-68</b> 19, that (I) (we) lost saw the deceased alive on <b>3-28-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Christina Abarrar-Feliciano M.D.</b>				23B. DATE SIGNED <b>3-28-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHRISTINA ABARRAR-FELICIANO</b>				23D. ADDRESS <b>FRANKLIN SQ HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3-30-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>		25D. ADDRESS <b>1217 St Paul St Balt., Md. 21201</b>			



A-223

68-3563 BALTIMORE CITY HEALTH DEPARTMENT

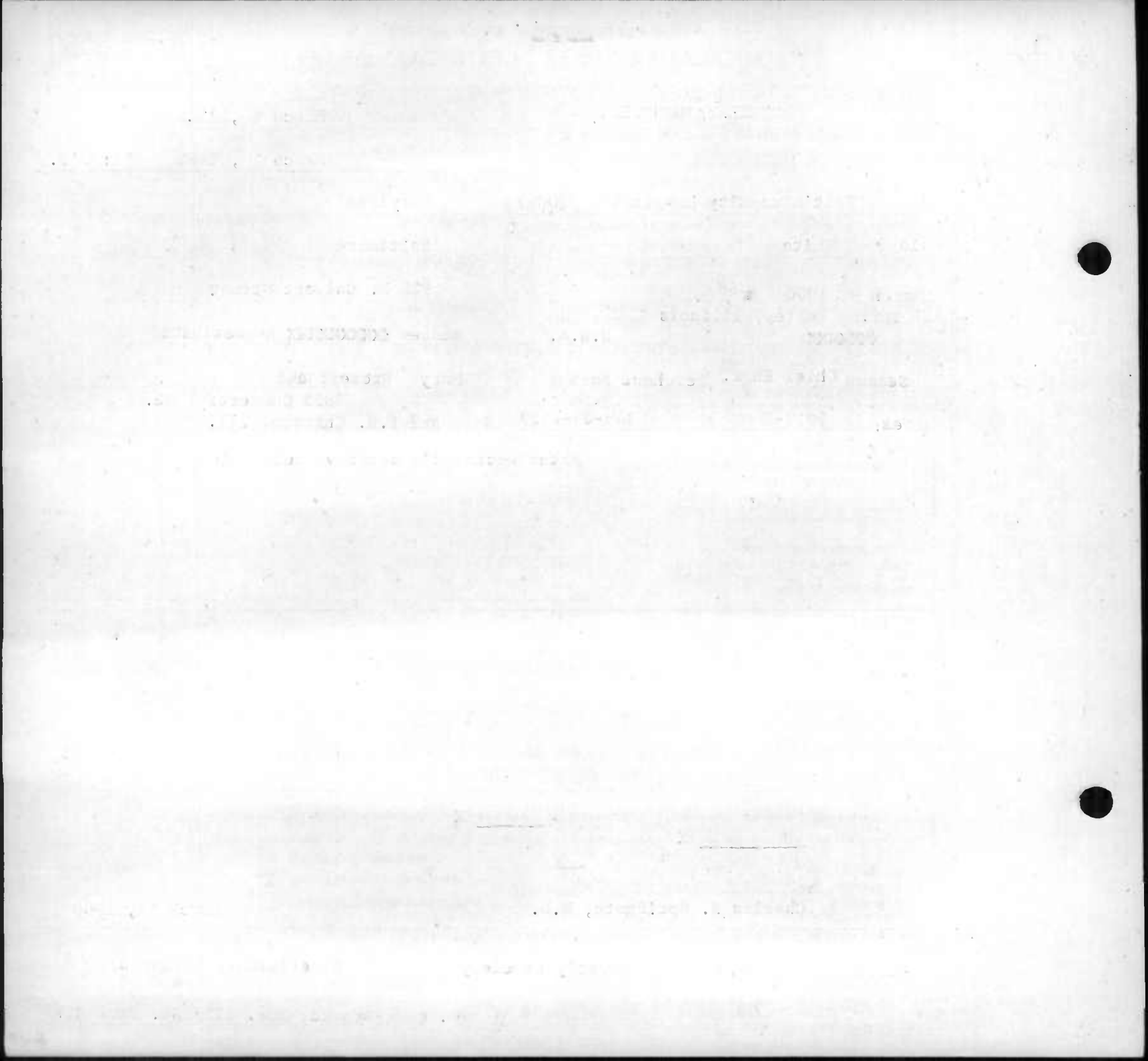
68-3563

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD STANLEY AUGUSTINE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>March 20, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 20, 1968 11:30 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>March 9, 1900</b>		10. AGE (In years last birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>Spring Valley, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman Chief Engr.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1919-?</b>		17. SOCIAL SECURITY NO. <b>349-05-7529</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Brezezinski</b>		18. INFORMANT <b>8832 Commercial St. Sadowski F.H. Chicago, Ill.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>4/2/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Beverly Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Blue Island, Illinois</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	



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68- 3564 BALTIMORE CITY HEALTH DEPARTMENT

68- 3564

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LONZO STRICKLAND</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>March 30, 1968</b> 9:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>505 Wyeth Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 30, 1968 9:50 A. M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>D. INSIDE CITY LIMITS</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Dec. 24, 1920</b>		10. AGE (In years lost birthday) <b>47</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Horry Co., S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brickmason</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		17. SOCIAL SECURITY NO. <b>251-24-0999</b>	
15. MOTHER'S MAIDEN NAME <b>Lillie Belle Sarvis</b>		18. INFORMANT <b>608 Beatty St. Gpldfinch F.H. Conway, S.C.</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>30 3-31-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Zoan Methodist Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>RFD#2 Galivants Ferry, S.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Ronald E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc.</b>		25D. ADDRESS <b>1217 St. Paul St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3555 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 3555

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DAVIS, JOSIAH WILLIAM</b>		2. DATE AND HOUR OF DEATH <b>MARCH 30, 1968 9:23 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVES. BALTIMORE, M.D. 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21228</b>		53.00	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11-30-83</b>		9. AGE (In years lost birthday) <b>84 83</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN SMELTING &amp; REFIN. COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>DAVID DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA Rachael</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212075274</b>		17. INFORMANT <b>BALTIMORE, MD. 21229 ST. AGNES RECORDS, WILKENS &amp; CATON AVES.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio vascular collapse</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24-</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C.V.D.</b>		(C) <b>Cerebral Anoxia</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 30 1968</b> to <b>MARCH 30 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>MARCH 30 1968</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>Alejandro Mejia MD</b>				23B. DATE SIGNED <b>MARCH 30, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA MD</b>		23D. ADDRESS <b>WILKENS &amp; CATON AVES. - BALTO MD. 212</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. 6212 Balto. Nat'l Pike.</b>			

V. S. 153 4-3-68 ~~MH~~.

U-523

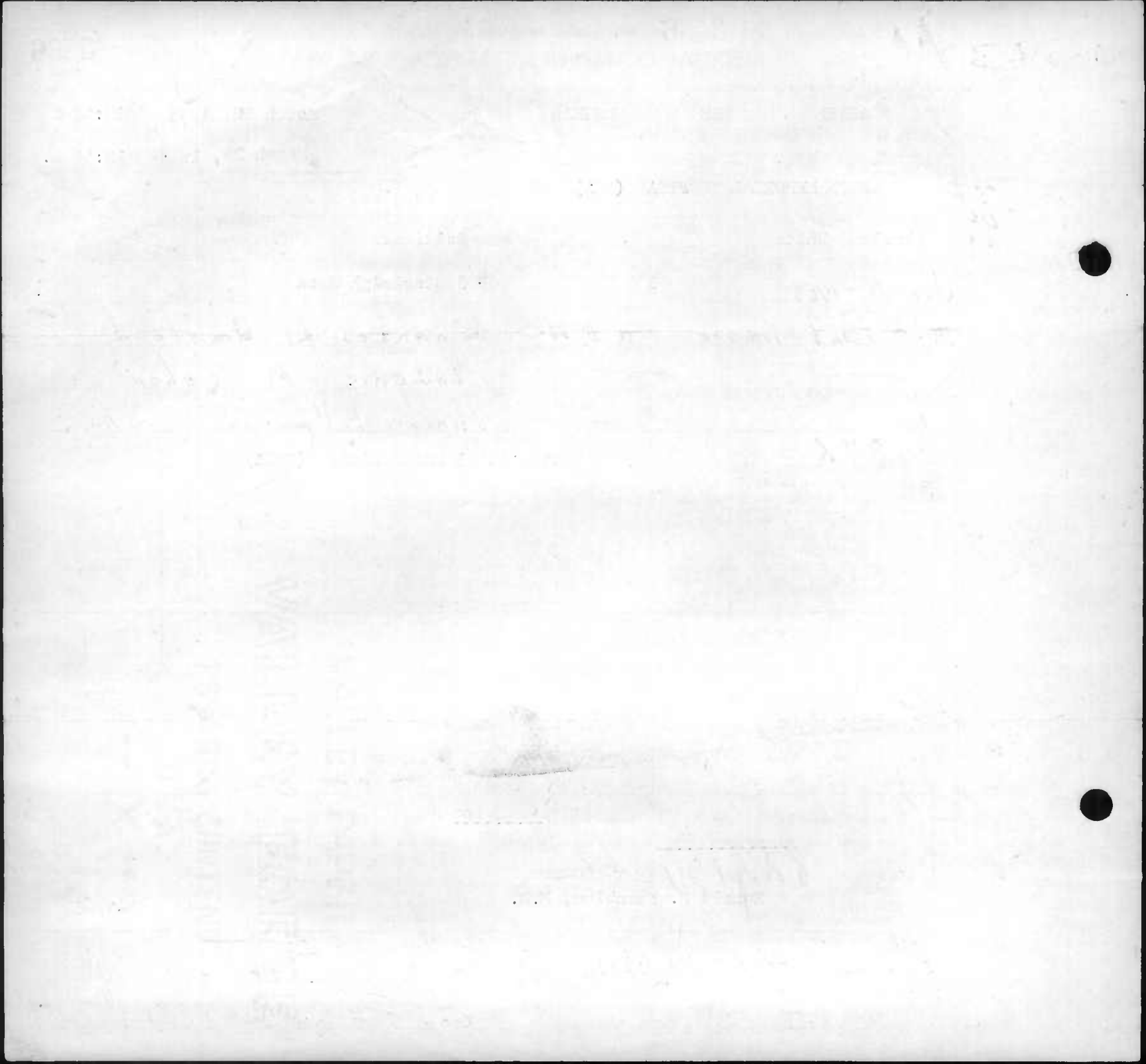
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 68-00979

REG. NO.

1. NAME OF DECEASED (Type or Print) APRIL DEE UMSTEAD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 29, 1968		Hour 10:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year March 29, 1968		Hour 10:40 A.M.	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan-16-1968		10. AGE (In years last birthday) 3		11. BIRTHPLACE (State or foreign country) Md - Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles L. Umstead		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Valerie M. Cohen		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT Charles L. Umstead		19. ADDRESS Same		20. CITY OR TOWN Baltimore	
21. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		22. STREET AND NUMBER 6005 Starleigh Road		23. A. STATE Maryland B. COUNTY Baltimore C. COUNTY 53-00	

MEDICAL CERTIFICATION	19. 484X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS (SDII) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
	20. 525X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
	20A. DATE OF OPERATION 3		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
	20C. AUTOPSY? (Yes or No) Yes				
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-29-68					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-1-1968		24C. NAME OF CEMETERY OR CREMATORY Garden of Faith	
24D. LOCATION Baltimore Md		24E. DATE REC'D BY HEALTH DEPT. APR 2 1968		24F. NAME OF REGISTRAR Robert E. Finkbeiner	
24G. FUNERAL DIRECTOR Charles F. Evanson		24H. ADDRESS 8802 Hartford Rd.			

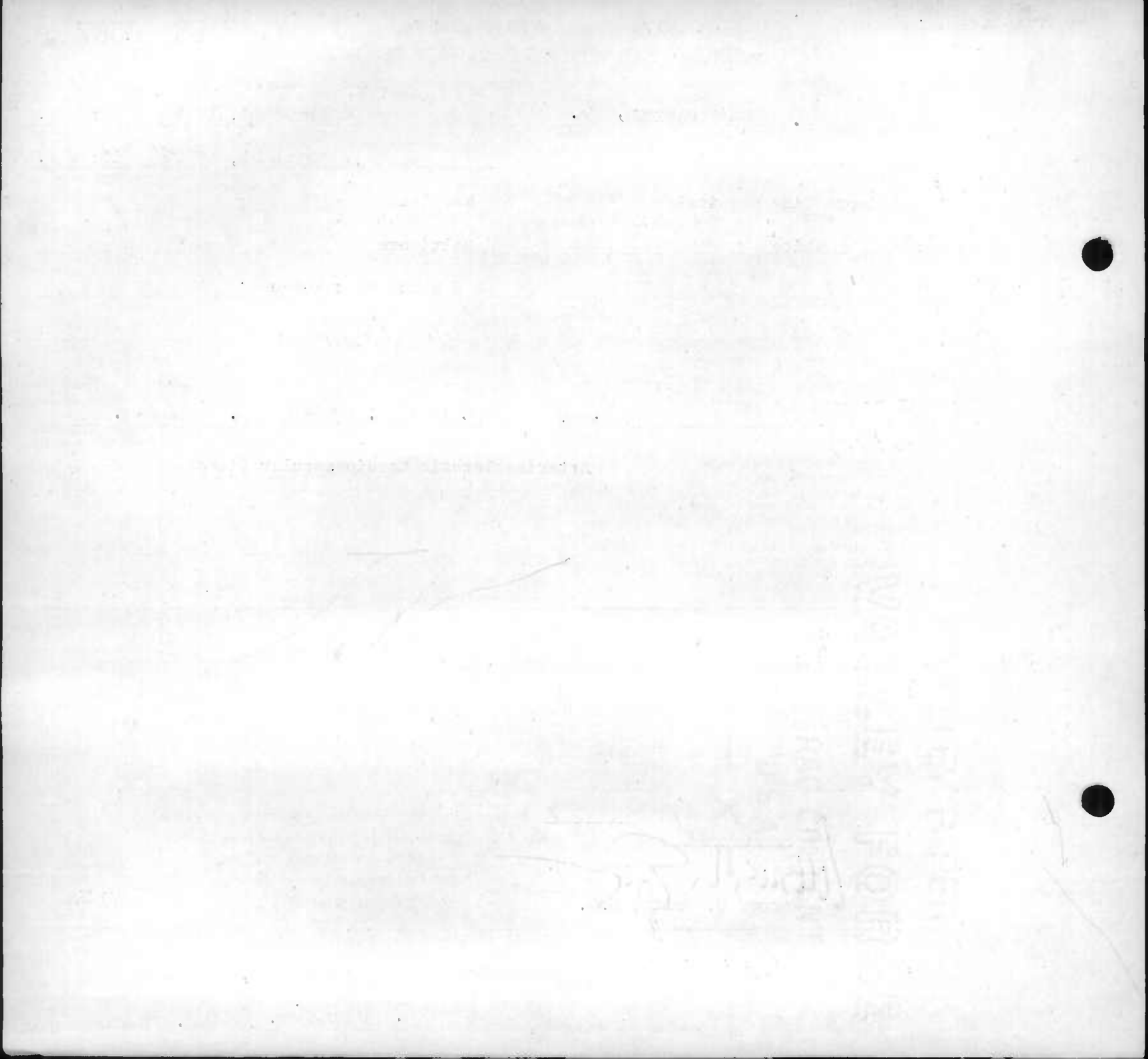


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EUGENE J. CANTON, Sr.</b>		2. DATE OF DEATH Known? <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>March 31, 1968 12:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 31, 1968 12:45 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10/10/'09</b>		10. AGE (In years lost birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Owner</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>unknown</b>	
18. INFORMANT <b>Mrs. Mary M. Canton</b>		ADDRESS <b>8 N. East Ave.</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>433.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/'68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley</b>	
25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>		ADDRESS <b>3000 E. Baltimore St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3568

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3568

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MENDENHALL LAURANCE B.</b>		2. DATE AND HOUR OF DEATH <b>3-30-68 12:30 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 The Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b> B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>942 Cator Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-28-96</b>	9. AGE (In years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Mobile, Alabama</b>	
13. FATHER'S NAME <b>Henry C. Mendenhall</b>		14. MOTHER'S MAIDEN NAME <b>Fannie McNeill, Frances</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marjory J. Mendenhall (Daughter)</b> Same	
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ch. Yeu</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>491X II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-25-1968</b> to <b>3-30-1968</b> , that (I) (we) last saw the deceased alive on <b>3-30-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Darwish M. Nazzal</b>				23B. DATE SIGNED <b>3-30-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DARWISH M. NAZZAL</b>				23D. ADDRESS <b>The Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/1/1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Parwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 2 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Seitz</b>		25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 2 1212</b>			

1945 Carter Avenue  
Baltimore  
Maryland

H-28-10

Francis M. C.

Francis M. C.

Henry C. Montgomery

10

2-22-68 2-22-68 2-22-68

Don't be noisy

DARWIN M. VASSAL The Prisoner

K-528

68- 3569 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3569

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD

KING

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

March 31, 1968

4:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 31, 1968

4:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

6-8-1948

10. AGE (In years  
lost birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

702 Mt. Holly Street

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

RUSSELL KING

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

VERNAL

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

219-507124

18. INFORMANT

ADDRESS

VERNAL BRYAN 702 MT HOLLY ST.

19.

304.91

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Bronchopneumonia complicating Nar-

(A) IMMEDIATE CAUSE

~~XXXXXXXXXXXXXXXXXXXX~~ cotic Addiction

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

323X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-4-68

24C. NAME of CEMETERY or CREMATORY

ARBUTUS MEM.

24D. LOCATION (City, town, or county)

ARBUTUS Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 2 1968

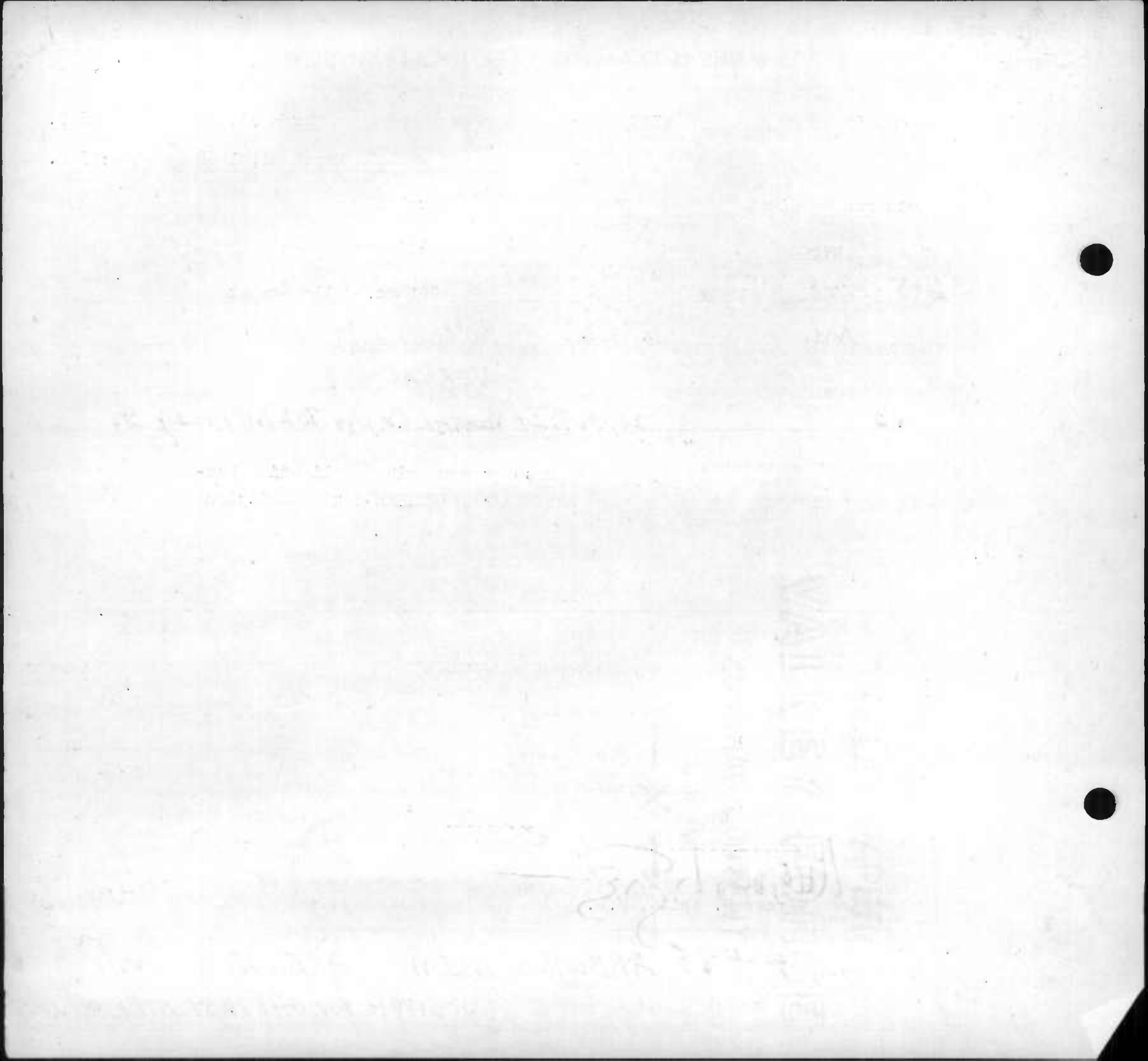
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

JOSEPH KNIGHT 1639 N. BROADWAY

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		68- 3570		CITY HEALTH DEPARTMENT		REG. NO.		68- 3570	
1. NAME OF DECEASED (Type or Print) <b>FARLEY, VIOLA</b>				2. DATE AND HOUR OF DEATH <b>3/29/68 2:30 P. M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>428 SIWAH HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-41</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3720 MILFORD AVE</b>					
5. SEX <b>F</b>	6. RACE <b>W N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/10/20</b>		9. AGE (In years lost birthday) <b>47</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Griffin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Campbell</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Coverlyn Campbell</b> ADDRESS <b>3720 Milford Ave</b>			
18. <b>430.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH <b>SUBARACHNOID HEMORRHAGE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>several years</b>	
19. DATE OF OPERATION <b>330 X II</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Alan F. Wolf</b>						23B. DATE SIGNED <b>3/29/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ALAN F. WOLF</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)						24B. DATE <b>APR 2 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Albans Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>						25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>	
25C. FUNERAL DIRECTOR <b>J. Brooks Fungold</b>						25D. ADDRESS <b>1463 N. Camp St</b>			

1910/11

1910/11

1910/11

1910/11

1910/11

1910/11

1910/11

P. 360

68- 3571

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3571

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>BARBARA M. POTTER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1968</b> 5:15 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>6304 Cardiff Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 30, 1968</b> 5:15 P. M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-36</b>	
9. DATE OF BIRTH <b>June 14, 1887</b>		10. AGE (In years lost birthday) <b>81</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Coopers Tavern</b>	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>217-09-2564</b>		18. INFORMANT <b>Charles Potter 18 N. Clinton St</b>	
19. <b>412.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic and Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Notural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-31-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Trinity Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>O'Donnel St Balto, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leo G. Cook 7200 Harford Rd</b>		ADDRESS	

John J. ...

U.S.A.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant, if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3572	
68-3572				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ruby A. Watkins</i>		2. DATE AND HOUR OF DEATH <i>12 AM 3/28/68</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore City</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>1-8-30</i>		9. AGE (In years last birthday) <i>38</i>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>Portsmouth, Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Emory Bowser</i>		14. MOTHER'S MAIDEN NAME <i>Jafarine Almond</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-26-2013</i>		17. INFORMANT <i>Mrs Jafarine Waters 2037 E. Lanvale St.</i> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>425X I</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i> (B) <i>Cardiomyopathy</i> (C) <i>Bronchial Asthma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i> <i>3 yrs.</i> <i>12 yrs.</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/16/68</i> to <i>3/28/68</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>George H. Reed MD</i>		23B. DATE SIGNED <i>3/28/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>GEORGE H. REED</i>		23D. ADDRESS <i>J.H.A.</i>		23E. DEGREE <i>MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-1-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Anne Arundel Co., Md.</i>		24E. STATE <i>Md.</i>		24F. ADDRESS <i>2434 E. Oliver St.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson, MA</i>		25C. FUNERAL DIRECTOR <i>Randolph J. Collick</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

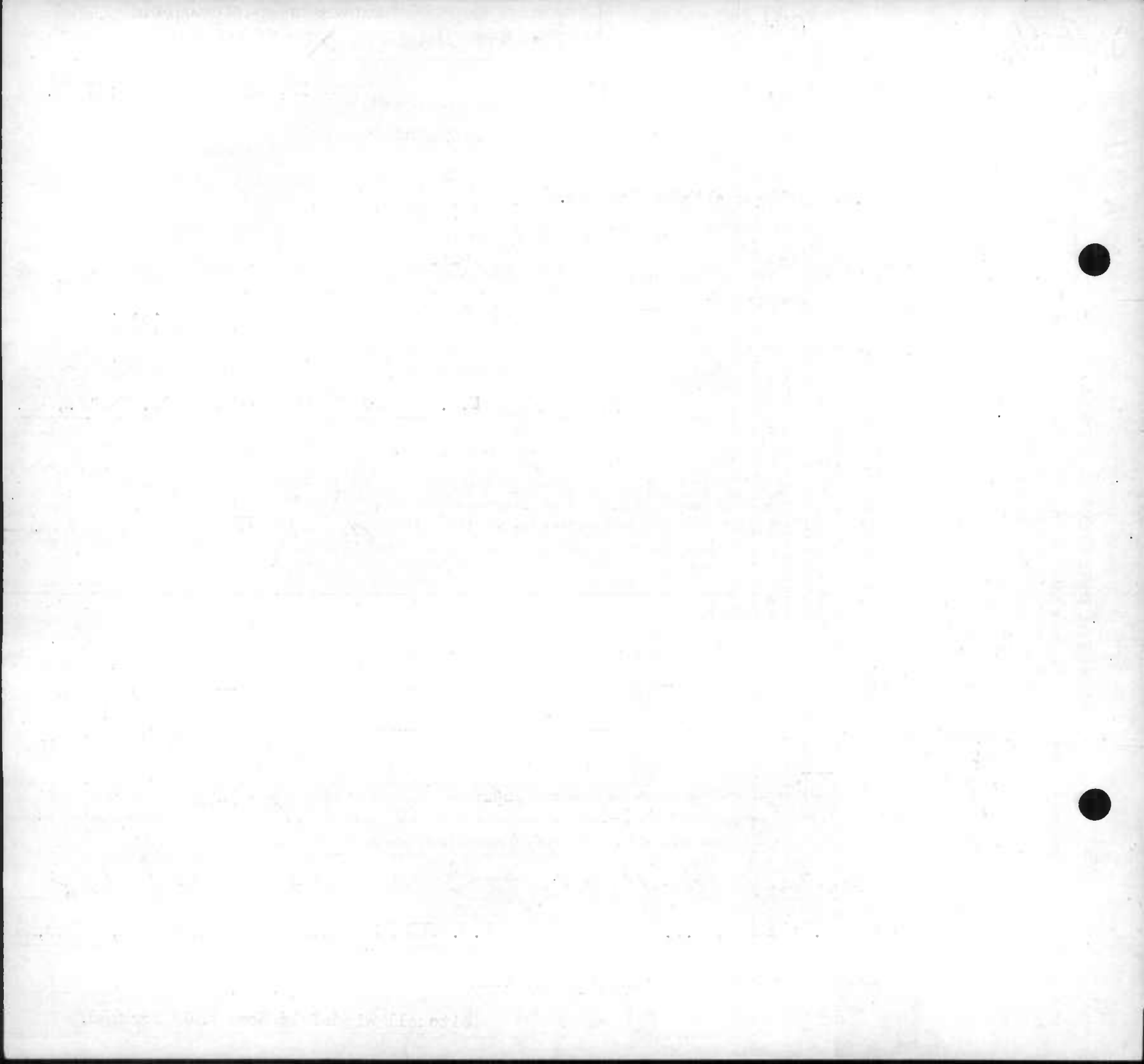
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3573</u>
BIRTH NO.		68-3573		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Helen K. Lorenz		3/27/1968 7:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  815 E. 41st Street		A. STATE Md. Baltimore		
		B. COUNTY		
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 815 E. 41st Street		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1896	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Wm. Kroening		14. MOTHER'S MAIDEN NAME Mary Walper		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Freda Carberry 817 E. 41st St.
18. <u>412.0 41 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute cardiac failure DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 15 yrs. 15 yrs. 7 yrs.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>443X II</u>				
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>April 17, 1961</u> to <u>March 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>March 27, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lloyd E. Saylor</u>		23B. DATE SIGNED March 29, 1968		23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor
23D. ADDRESS 3902 Greenmount Ave		23E. DATE REC'D BY HEALTH DEPT. APR 2 1968		
23F. NAME OF REGISTRAR <u>Robert E. Taylor</u>		23G. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/30/1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemt.
24D. LOCATION Baltimore, Md.		24E. (City, town, or county) (State)		

Thos. B. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="float: right;">68- 3574</span>	
CERTIFICATE OF DEATH				REG. NO. <span style="float: right;">68- 3574</span>	
1. NAME OF DECEASED (Type or Print) <b>PUESCHEL, Clotilda Johanna</b>			2. DATE AND HOUR OF DEATH <b>March 31, 1968 10:17 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2X U.S. Public Health Service Hosp/</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>203 Murdock Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-1908</b>		9. AGE (In years last birthday) <b>59</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Oswald Pueschel</b>		
14. MOTHER'S MAIDEN NAME <b>Louise Arold</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214 40 4461</b>			17. INFORMANT <b>U.S. PUBLIC HEALTH SERVICE HOSP. Balto., Md.</b>		
18. <b>183.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Progressive tumor &amp; inanition</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pseudomucinous epidermoid carcinoma of ovary = pseudomyxoma peritonei</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>approx 2 years</b> <b>approx 2 years</b>		
19. DATE OF OPERATION <b>175.0 II</b>			20. AUTOPSY? (Yes or No) <b>No</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>---</b>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>---</b>		
22. I certify that (1) (this hospital) attended the deceased from <b>1-3-68</b> to <b>3-31-68</b> and that (1) (we) last saw the deceased alive on <b>3-31-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Martin D. Abeloff, M.D.</b>			23B. DATE SIGNED <b>4/1/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>Martin D. Abeloff, M.D.</b>			23D. ADDRESS <b>U.S. PUBLIC Health Service Hospital, Balto, Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>		25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home 6500 York Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. 68-- 3575			
1. NAME OF DECEASED (Type or Print) MC CURRY, ROBERT JOHN				2. DATE AND HOUR OF DEATH MARCH 31, 1968 11:15 P. M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CATONSVILLE 21228 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1027 MARKSWORTH RD. 53-00											
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05/05/93		9. AGE (In years lost birthday) 74		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY PENNA. R.R.				11. BIRTHPLACE (State or foreign country) Pittsburgh				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME PATRICK MC CURRY				14. MOTHER'S MAIDEN NAME MARGARET J. SLOANE											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 716-18-1061				17. INFORMANT WILKENS & CATON AVES ST. AGNES RECORDS, BALTO., MD. 21229							
18. 412-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: C.V.D. (C) D.S.-C.V.-D.-				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION 4-3-68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 03/27/68 19 to 03/31 19 68, that (I) (we) last saw the deceased alive on MARCH 31 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE George Dwyer				23B. DATE SIGNED											
23C. PHYSICIAN'S NAME (Type) GEORGE DWYER				23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4-3-68				24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM.				24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 2 1968				25B. NAME OF REGISTRAR Robert E. Taylor, MA				25C. FUNERAL DIRECTOR ADDRESS 5311 WEBER FUNERAL HOME EDMONDSON AVE							

*James*

CVB  
B-1-C-V-D-

*George H. H. H.*  
GEORGE H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3576</span>	
68- 3576				CERTIFICATE OF DEATH	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>MR. CHARLES CZARSKI</b>			MAR. 31, 1968 3:30 P.M. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>			<b>521 S. DALLAS STREET</b>		
5. SEX <b>M</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POICEMAN</b>			E. STREET AND NUMBER <b>MARYLAND 21231</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>CITY BALTO MD</b>			9. AGE (In years lost birthday) <b>72</b>		
13. FATHER'S NAME <b>VALENTINE CZARSKI</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W/W I</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
16. SOCIAL SECURITY NO. <b>220-07-0227</b>			14. MOTHER'S MAIDEN NAME <b>KLEIN</b>		
17. INFORMANT <b>VERONICA CZARSKI</b>			ADDRESS <b>521 DALLAS ST</b>		
18. CAUSE OF DEATH <b>571.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Varicose vein bleeding (esophageal)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>581.0</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>III</b> <b>581.0</b> 19A. DATE OF OPERATION <b>3/31/68</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Portacaval Shunt</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. AUTOPSY? (Yes or No) <b>YES</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>2/8/68</b> 19 to <b>3/31/68</b> 19, that (I) (we) last saw the deceased alive on <b>3/31/68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. Albina</b>			23B. DATE SIGNED <b>3/31/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>B. ALBINA</b>			23D. ADDRESS <b>Church Home &amp; Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>DUNDALK MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b> 25B. NAME OF REGISTRAR <b>Robert E. Sawyer, M.D.</b>			
25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC. CHESTER ST</b> ADDRESS <b>401</b>					

From a woman in the  
hospital  
in the  
hospital

Received from

2/1/52

F. ALBINA  
F. ALBINA

2/1/52  
Check from a woman in the hospital

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PHILLIP A. JOHNSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> Hour <b>12:20 A</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 29, 1968 12:20 A</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 19, 1951</b>		10. AGE (In years, lost birthday) <b>17</b> <sup>26</sup> <sub>26</sub> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handy Man</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Evelyn Johnson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>218-52-3539</b>		18. INFORMANT <b>Mrs. Evelyn Johnson</b> ADDRESS <b>3220 Windsor Ave.</b>	
19. <b>E966X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Stab wound of neck, left side</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Front of 2610 Allendale Road</b>		22D. TIME (Month) (Day) (Year) (Hour) (Min.) OF INJURY (APPROX.) <b>3 29 68 11:45 P.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>3-30-68</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Carmel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Westport (Baltimore) Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Joseph L. Russ</b>		25D. ADDRESS <b>2222 W. North Ave. Baltimore, Md.</b>	

Mr. A. M. 17 11  
Baltimore, Md.  
March 1888

Robert Johnson  
Baltimore, Md.

On receipt of the above please return to the

Wm. H. Miller

March 1888  
11/2/88  
Wm. H. Miller  
Baltimore, Md.  
Receipt of above please return to the

68- 3578

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3578

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) ALVIN

WARREN

2. DATE  
OF  
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

March 29, 1968

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

48 MARYLAND GENERAL HOSPITAL

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 29, 1968

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS

YES ☐NO ☐

9. DATE OF BIRTH

Sept. 10, 1960

10. AGE (In years  
lost birthday)

7

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2351 Eutaw Place

11. BIRTH PLACE (State or foreign country)

Suffolk, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Benny Warren

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sherlene C. Cary

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Benny Warren 2351 Eutaw Place

19. E 814.7 I

CAUSE OF DEATH

Multiple Traumatism Injuries

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(8)

DUE TO, OR AS A CONSEQUENCE OF:

(c)

E 812.4 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

900 Bk. Whitelock Street

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY 3 29 68 11:30  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. struck by hit-and-run driver

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/2/1968

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery, Westport (Baltimore) Md.

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

APR 2 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Joseph L. Russ

ADDRESS

2351 W. Baltimore

Baltimore, Md.

Paul W. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-320		68-- 3579		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-- 3579	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) REITZ, ANN P			
2. DATE AND HOUR OF DEATH MARCH 30, 1968 10:45P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21229 B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4516 MANORDENE RD.		5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-19-97		9. AGE (In years last birthday) 70		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME EMIL REITZ			
14. MOTHER'S MAIDEN NAME ELIZABETH BENSING				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214207539				17. INFORMANT ADDRESS BALTIMORE, MD. 21229 ST. AGNES RECORDS, WILKENS & CATON AVES			
18. 436.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE C.V.A. DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				MEDICAL CERTIFICATION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from MARCH 30 19 68 to MARCH 30 19 68, that (X) (we) last saw the deceased alive on MARCH 30 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (d) view the body after death.		23A. SIGNATURE Oscar E. Laborda DEGREE	
23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) OSCAR LABORDA DEGREE		23D. ADDRESS CATON & WILKENS AVES. BALTO 21229 MD.		23E. FUNERAL DIRECTOR ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) Baltimore Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	

ST. ALGER STREET, N. Y. 2

BALTIMORE, MD.

BOSTON, MASS.

ST. ALGER STREET, N. Y. 2

XX

XX

ST. ALGER STREET, N. Y. 2

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3580

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3580

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GENOVESE, Joseph Jr.</b>		2. DATE AND HOUR OF DEATH <b>4/1/68</b> <b>6 A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b> <b>33</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5005 Schaub Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-14-1895</b> <del>10-14-1895</del>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Joseph Genovese, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Verna Smilordi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-28-8777</b>		17. INFORMANT <b>Joseph Genovese 111-5005 Schaub Avenue</b>	
18. <b>412.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443x II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b> (B) <b>HACVD</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 HRS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>68</b> to <b>4/1</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/1</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry K Genant</b> DEGREE				23B. DATE SIGNED <b>4/1/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Harry K. Genant</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Ellsworth Armacost-4600 Liberty Hghts.</b>			

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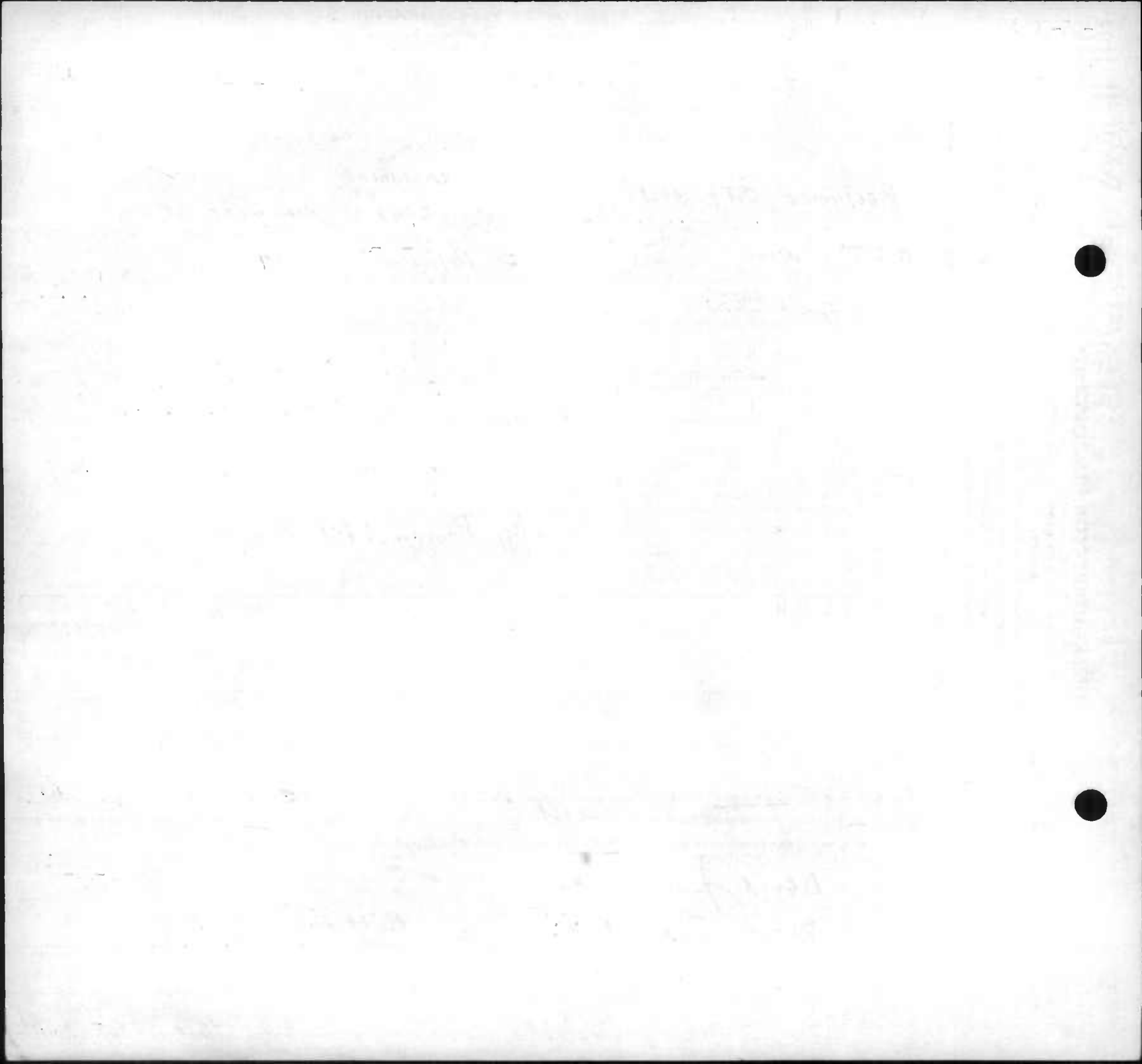
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3581	
BIRTH NO. J-520 68-3581				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ANITA JONES ANITA M. JONES		2. DATE AND HOUR OF DEATH 3/31/68 6:40 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224		A. STATE MARYLAND		B. COUNTY BALTIMORE	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2342 E. MONUMENT ST. #21205					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-16-40	9. AGE (In years lost birthday) 27	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress WAITRESS
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CHARLES JONES		14. MOTHER'S MAIDEN NAME HENRIETTA S. NORB			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-36-597		17. INFORMATION FROM RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic abortion → coma, (B) 2 hyperthermia ↑ ICP, Seizure DUE TO, OR AS A CONSEQUENCE OF: (C) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/1967 3/1967	
19A. DATE OF OPERATION 6-5-60		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/29 to 3/31 1968, that (I) (we) last saw the deceased alive on 3/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Juan		23B. DATE SIGNED 3/31/68		23C. PHYSICIAN'S NAME (Type) DAVID JUAN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-68		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24D. LOCATION BALTIMORE, MD		25A. DATE REC'D BY HEALTH DEPT. APR 2 1968		25B. NAME OF REGISTRAR E. E. Faldy	
25C. FUNERAL DIRECTOR Ellsworth Armacost		25D. ADDRESS 4600 Liberty Hgts			



G 6150  
S-300

68- 3582

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3582

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LILLIE R. GREEN SCOTT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>March 29, 1968</b> 11:00 P.M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>May 10-1930</b>		10. AGE (In years last birthday) <b>37</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>FRANKLIN N.C.</b>		12. CITIZEN OF <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES W SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA STEELE</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		16. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH <b>345,914-E887A</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Sudural Hematoma</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>3-3-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unk.</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unk.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>March ? 68 ?</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. Apparently fell during epileptic seizure</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-30-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>3/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	
25C. FUNERAL DIRECTOR <b>Manuel P. Pappas</b>		ADDRESS <b>1111 Appleton St</b>	

Wm. McKelvey

**FUNERAL DIRECTOR: IMPORTANT**

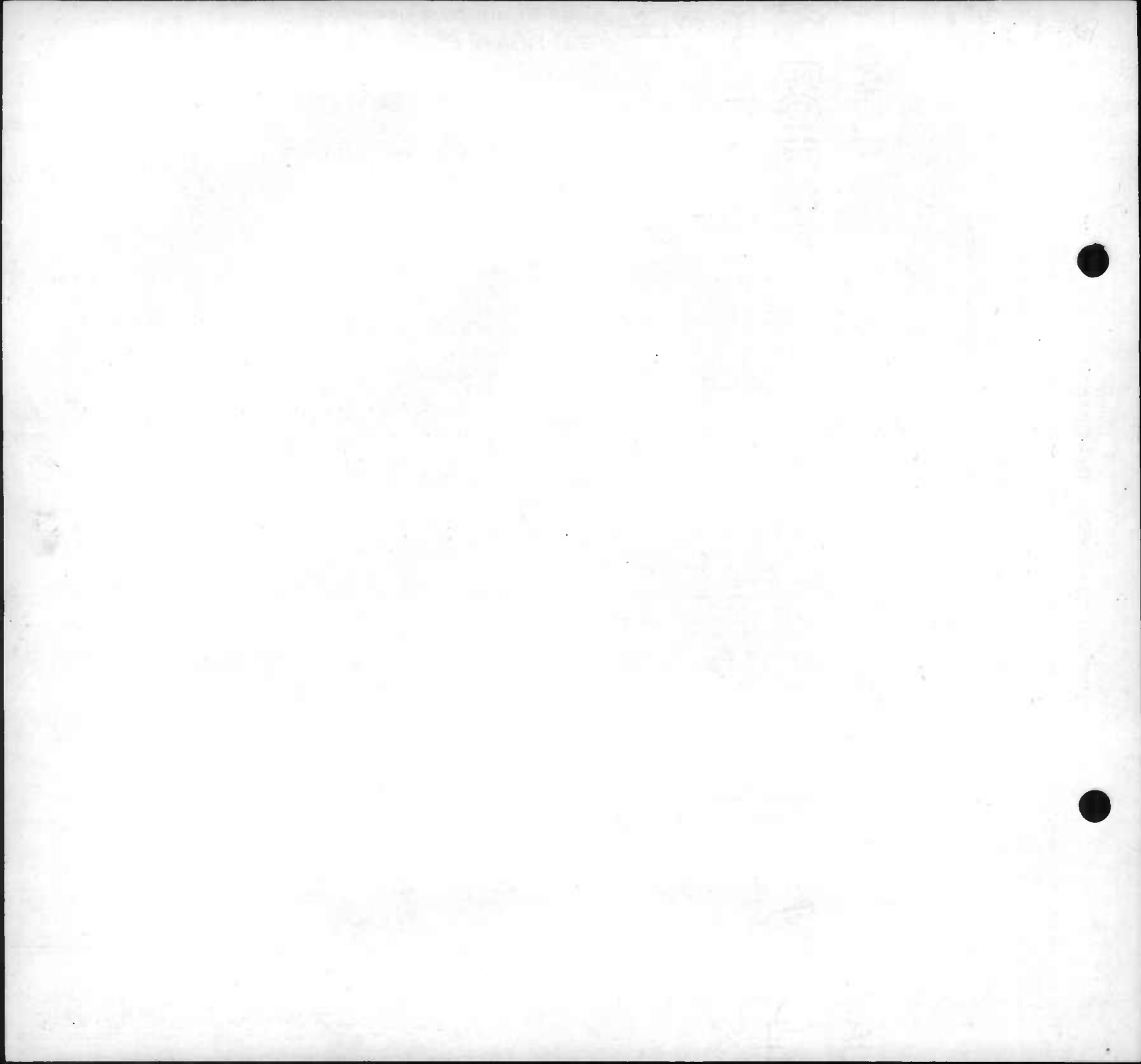
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3583

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3583

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FRANCIS DAVIS</b>		2. DATE AND HOUR OF DEATH <b>MARCH 30, 1968 13:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY 38 HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>NBGR</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>WILLIAM DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>MARY EDWARDS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>VIRGINIA FIELDS 726 N. MONROE ST</b>	
18. <b>5-31-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA + PERITONITIS</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>540.1 II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PERFORATED STOMACH</b>		<b>10 DAYS</b>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>GASTRIC ULCER</b>		<b>10 MONTHS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ARTERIO SCLEROSIS</b>					
19A. DATE OF OPERATION <b>3/12/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC ULCER</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/6/68</b> <b>1968</b> to <b>3/30</b> <b>1968</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Charles A. Harrison MD</b>				23B. DATE SIGNED <b>3/30/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES A. HARRISON MD</b>				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>Man Sam P. Hays</b>		ADDRESS <b>5638 N. GILMAN ST</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3584

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3584

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GRIFFIN, Frank (NMI)		3/27/68 11:50 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1609 W. Lanvale Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/22/95	73	Laborer Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer Retired		Unknown		Alabama	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Hugh N. Cole			Mary F. Lawson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes 6/19/18 to 12/13/18		205-01-3109		Records VAH, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.91 Left middle cerebral artery thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332X II Pulmonary infarction OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acute myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days 10 years + 3 weeks 3 weeks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (u) (this hospital) attended the deceased from 2/17 19 68 to 3/27 19 68, that (u) (we) last saw the deceased alive on 3/27 19 68 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (not) view the body after death.					
23A. SIGNATURE Richard H. Anderson M.D.				23B. DATE SIGNED March 28, 1968	
23C. PHYSICIAN'S NAME (Type) RICHARD H. ANDERSON, M.D.				23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/2/68		BALFOUNATIONAL	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Baltimore		Baltimore			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 2 1968		Robert E. Johnson		Mamie R. Johns 638 N. Gilmor St	

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

[Illegible body text]

[Illegible body text]

1  
S-252

68- 3585 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3585

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)  
HORACE

SESSOMS

2. DATE  
OF  
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☒

March 29, 1968

11:00 A.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00811 Park Avenue - rear basement

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 1, 1968

9:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-5-1910

10. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2435 Edmondson Avenue

11. BIRTHPLACE (State or foreign country)

WHALEYVILLE VA

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

AUGUSTUS SESSOMS

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

MAINTENANCE

14B. KIND OF BUSINESS OR INDUSTRY

REALTOR

15. MOTHER'S MAIDEN NAME

REBECCA ROBERTS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

17. SOCIAL  
SECURITY NO.

E953X

18. INFORMANT

NELLIE SESSOMS 2435 Edmondson Ave

ADDRESS

19.

E953X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Hanging

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

E974X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

O

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

house

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

811 Park Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

4/1/68

UNK

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. hung self

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-5-68

24C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

24D. LOCATION (City, town, or county)

BALTO MD

25A. DATE RECEIVED BY HEALTH DEPT

APR 1 1968

25B. NAME OF REGISTRAR

Robert E. Sisk

25C. FUNERAL DIRECTOR

Marshall P. Hays

ADDRESS

638 N. Gilmor St



FUNERAL DIRECTOR: IMPORTANT

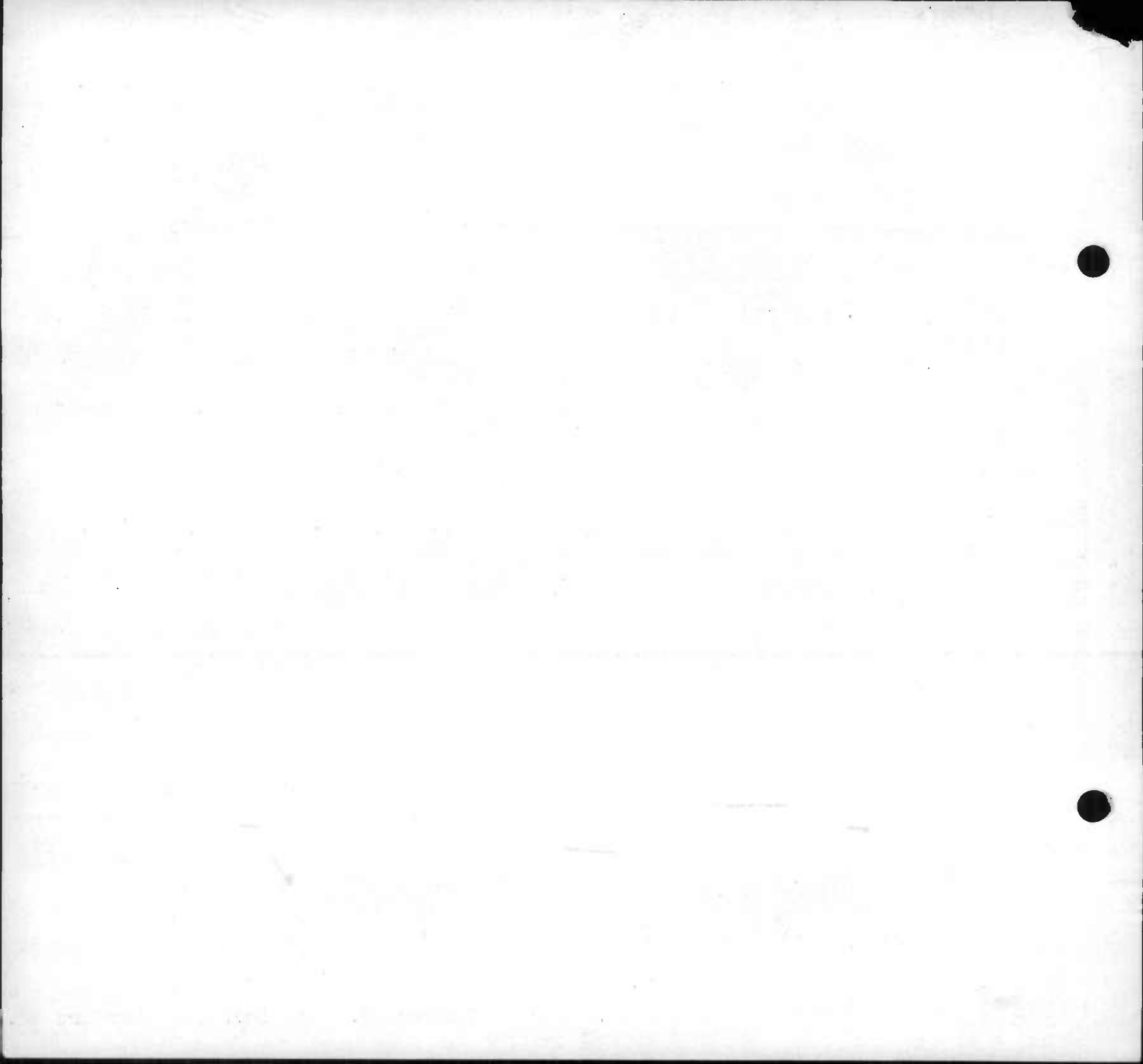
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3586

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3586

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Amelia</i> <i>Emily A. GARDNER</i>		2. DATE AND HOUR OF DEATH <i>4-2-68</i>   <i>12:40 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>		5. AGE (In years last birthday) <i>63</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4331 Berger Ave</i>		6. RACE <i>CAUC.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1-4-05</i>		9. AGE (In years last birthday) <i>63</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sec'y Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Stephen Gardner</i>	
14. MOTHER'S MAIDEN NAME <i>XXXXXXXXX Frances Jamroz</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216 10 8305</i>	
17. INFORMANT <i>Family- Mr. Stephen F. Gardner-Same</i>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary edema</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Acute myocardial infarct. hours.</i> <i>Arterio sclerotic cardiovascular disease years</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-1-1968</i> to <i>4-2-1968</i> , that (I) (we) last saw the deceased alive on <i>4-2-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hashemi</i> M.D. DEGREE				23B. DATE SIGNED <i>4-2-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. TAASAB HASHEMI</i> M.D. DEGREE				23D. ADDRESS <i>Bon Secours Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/5/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>st. Stanislaus Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Farley</i>	
24G. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>		24H. ADDRESS <i>5305 Harford Rd.</i>		24I. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret Mary O'Byrne</b>		2. DATE AND HOUR OF DEATH <b>3-31-68 8:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Gould Nursing Home 6116 Belair Rd.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F.</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-89</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Patrick O'Byrne</b>		14. MOTHER'S MAIDEN NAME <b>Bridgit Burke</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-5028</b>		17. INFORMANT <b>Margaret Leschefsky, 1703 Heathfield Rd.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive C-V disease</b> <b>Arteriosclerosis</b> <b>Uremic poisoning</b> <b>Fract. rt femur</b>		CAUSE OF DEATH <b>Arteriosclerosis</b> <b>Uremic poisoning</b> <b>Fract. rt femur</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>3/31/68</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X II</b>		19A. DATE OF OPERATION <b>1-31-68 5:00 P.M.</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fract. rt femur</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? <b>1703 Heathfield Rd</b>		21D. TIME OF INJURY (APPROX.) <b>1-31-68 5:00 P.M.</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>fell</b>		22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 17 1968</b> to <b>March 31 1968</b> , that (I) <del>lost</del> saw the deceased alive on <b>March 30 1968</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.	
23A. SIGNATURE <b>H. V. Harbold M.D.</b>		23B. DATE SIGNED <b>April 1, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Harold V. Harbold, M.D.</b>	
23D. ADDRESS <b>4706 Harford Rd.</b>		23E. DEGREE <b>Baltimore 14 Md</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>4-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>	

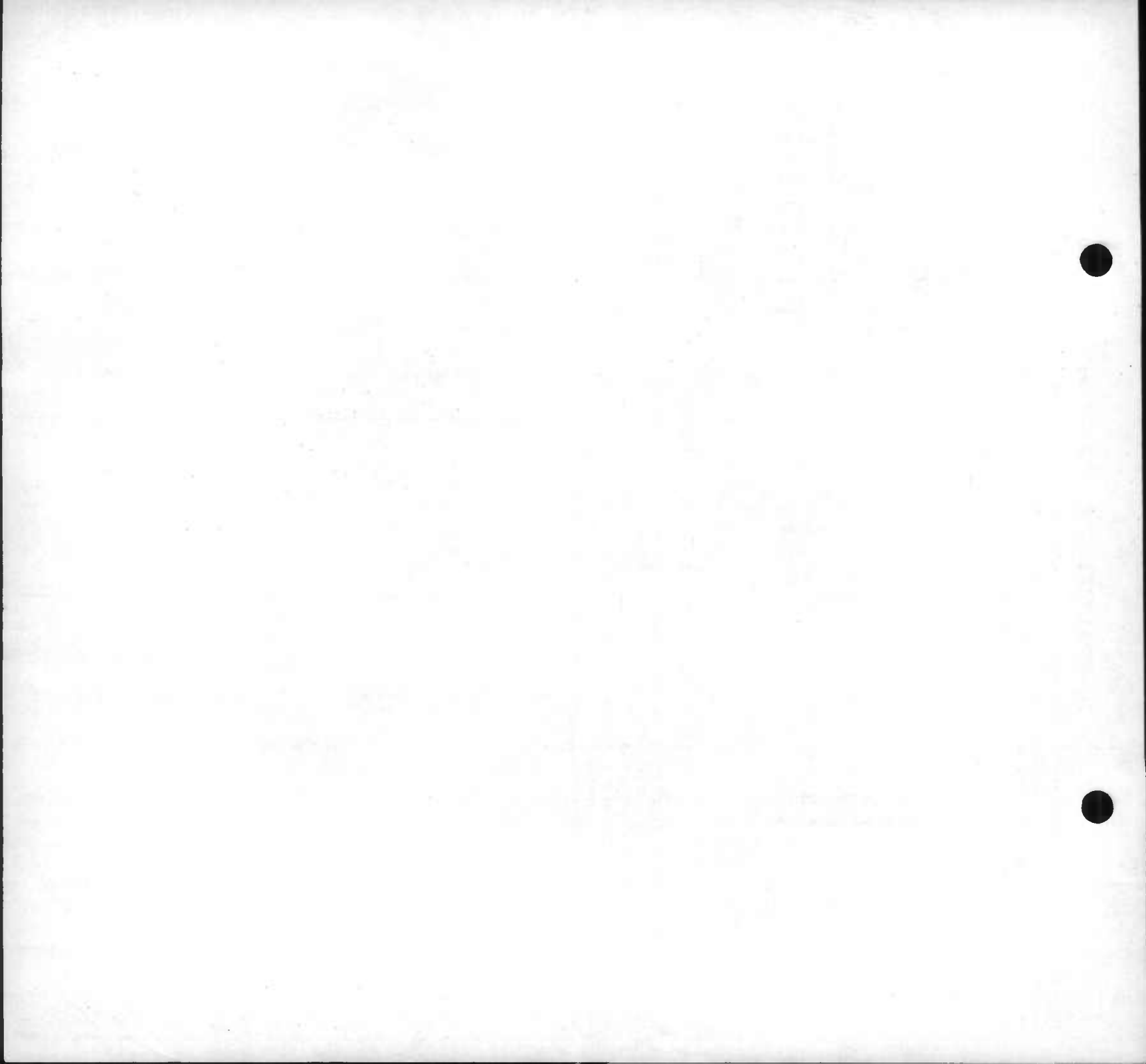
Alfred C. V. Brown  
B. Brown  
B. Brown  
B. Brown  
B. Brown

March 27, 1888  
J. V. Starnes  
X  
B. Brown  
B. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

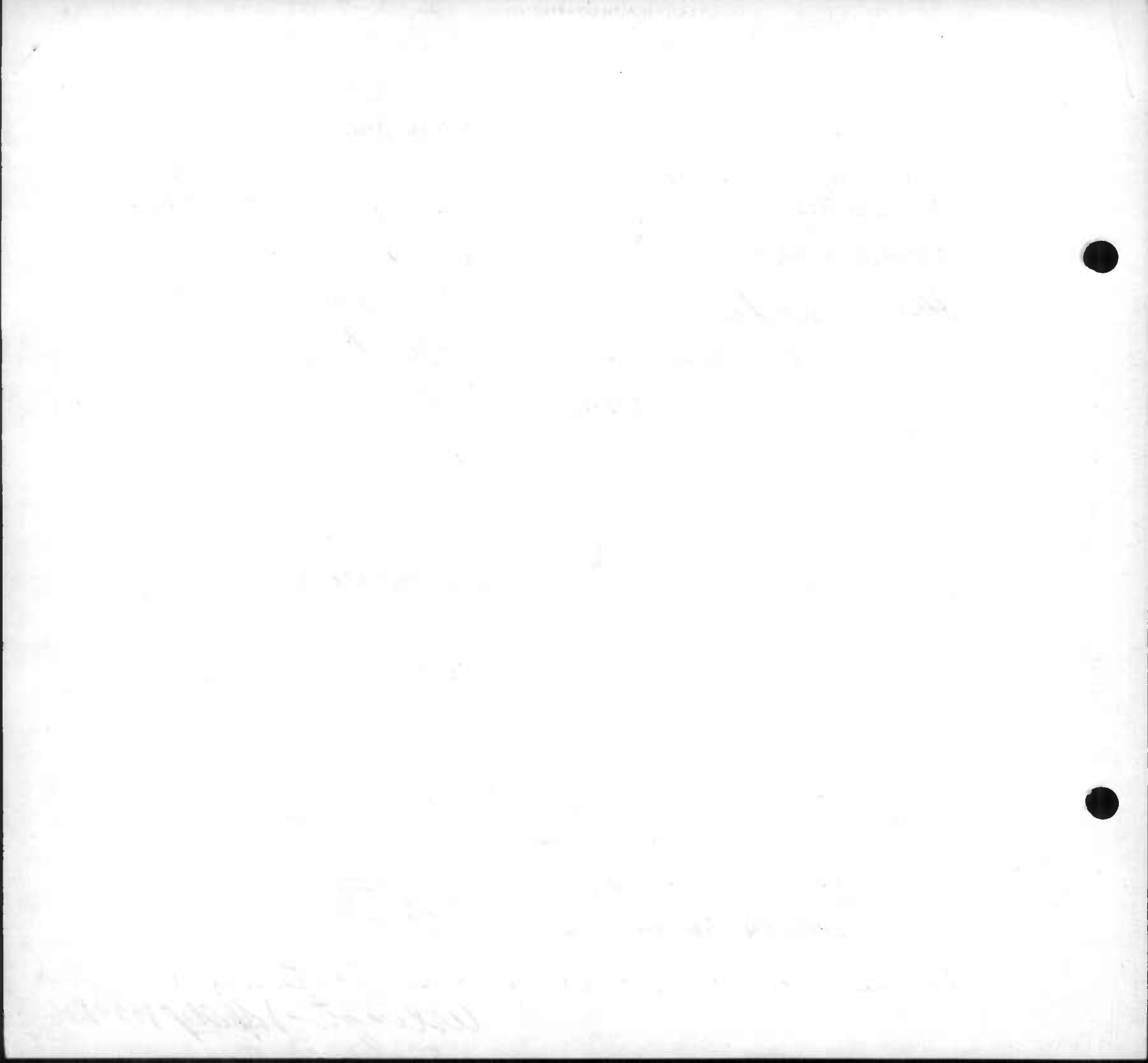
G-600		68-3588		BALTIMORE CITY HEALTH DEPARTMENT		68-3588	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO.</span> </div>							
1. NAME OF DECEASED (Type or Print) <i>Willie L. Gray</i>				2. DATE AND HOUR OF DEATH <i>3/24/68 7:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 Sinai Hospital of Baltimore</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2421 Shirley Ave #15</i>			
5. SEX <i>M.</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/16/20</i>	9. AGE (In years last birthday) <i>47</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Social Security</i>		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Marion Gray</i>				14. MOTHER'S MAIDEN NAME <i>Lucille Smith</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Willie Mae Gray</i> ADDRESS <i>2421 Shirley Ave.</i>			
18. <i>437.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) <i>Hypertensive cerebral vascular disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>4 yrs.</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>331X II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>March 20 1968</i> to <i>March 24 1968</i> , that (1) (we) last saw the deceased alive on <i>March 24 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Benjamin A. Kropshy M.D.</i>				23B. DATE SIGNED <i>March 24, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Benjamin A. Kropshy, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-29-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Wilmington Phillips</i>		25D. ADDRESS <i>1722 N. East</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-- 3589</u>
B-652		68-- 3589		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>CAROLYN BARNES</u>		2. DATE AND HOUR OF DEATH <u>3. 28.68.</u> <u>7:15 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 LUTHERAN HOSPITAL OF MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY _____ C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2000 WESTWOOD AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6. 15. 12</u>	9. AGE (In years last birthday) <u>55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Frank Moore</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>216-16-6025</u>		17. INFORMANT <u>Osborne Same</u>
18. <u>450X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Cardiac Failure</u> (B) <u>Pulmonary Embolism + Infarct</u> (C) <u>Pulmonary Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 mths.</u> <u>6 mths. ago</u> <u>2 mths. ago</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>465X II</u>				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>YES.</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>1. 30. 19 68</u> to <u>3. 28. 19 68</u> , that <del>the</del> (we) last saw the deceased alive on <u>3. 27. 19 68</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) <del>did not</del> view the body after death.				
23A. SIGNATURE <u>S. Shereen</u>		23B. DATE SIGNED _____		23C. PHYSICIAN'S NAME (Type) <u>SHEREEN SHEIKH</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-1-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>
24D. LOCATION (City, town, or county) (State) <u>Pactonville MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fadden</u>		25C. FUNERAL DIRECTOR <u>Arlingth S. Shereen</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

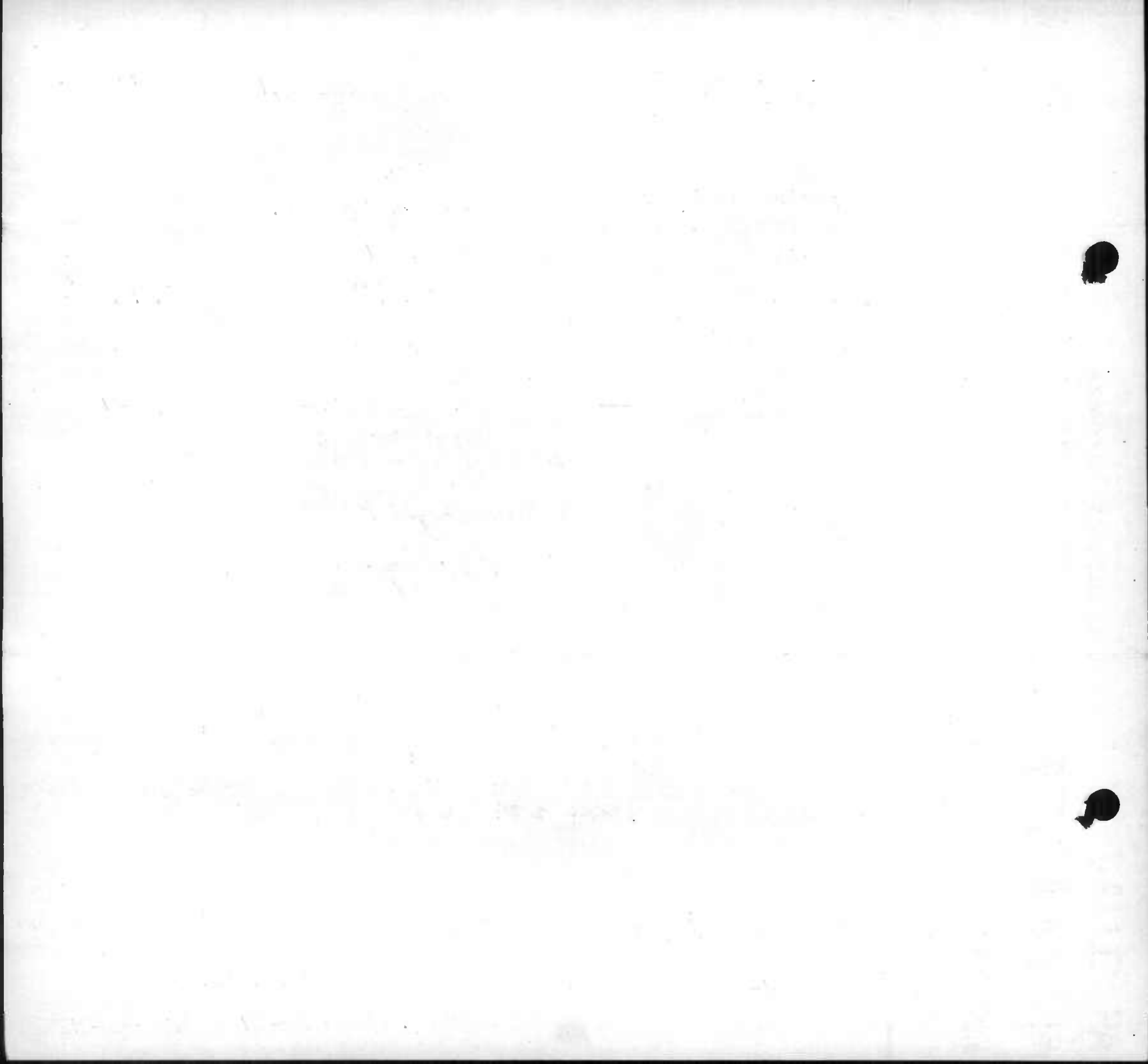
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 3590</u>
<b>1. NAME OF DECEASED</b> (Type or Print) <u>Margaret Groves Lentz</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>March 30, 1968</u> <u>12.50 P M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>624 E. 36th St.</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>624 E. 36th St.</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/28/1890</u>	<b>9. AGE</b> (In years last birthday) <u>77</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		
<b>13. FATHER'S NAME</b> <u>Albert Sidney Groves</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucretia Harris</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-24-4483</u>		<b>17. INFORMANT</b> <u>Mrs. Margaret V. Benner, 5515 The Alameda</u>
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive &amp; Atherosclerotic Cardiovascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>443X II</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  				
<b>19A. DATE OF OPERATION</b>  		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  		<b>20A. AUTOPSY?</b> (Yes or No) <u>No</u>
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)  		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)  		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>  				
<b>22. I certify that (I) (this hospital) attended the deceased from <u>13 April 1968</u> to <u>30 Mar 1968</u>, that (I) (we) last saw the deceased alive on <u>20 Mar 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Dr. Anderson M. Renick</u>				<b>23B. DATE SIGNED</b> <u>1 Apr 1968</u>
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>Dr. Anderson M. Renick</u>		<b>23D. ADDRESS</b> <u>1010 St. Paul St.</u>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>4/2/68</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Woodlawn</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore County, Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>APR 2 1968</u>		
<b>25B. NAME OF REGISTRAR</b> <u>R. E. Jenkins</u>		<b>25C. FUNERAL DIRECTOR</b> <u>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 3591
D-362		68- 3591		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Eva May Dietrich</i>			2. DATE AND HOUR OF DEATH <i>March 27, 1968</i> 4:30 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>90 Garrison Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY  C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <i>2803 Garrison Blvd.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 24, 1881</i>	9. AGE (In years last birthday) <i>86</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Wallace Jannett</i>			14. MOTHER'S MAIDEN NAME <i>Alice Fields</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. ---		17. INFORMANT <i>Mrs. Alma Morris - 7 Manor Avenue - 21206</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>420.1 II</i>			CAUSE OF DEATH <i>Coronary Occlusion due to Coronary Heart Disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized Arterio Sclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Old age</i> (C) _____		
19A. DATE OF OPERATION <i>420.1 II</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1965</i> 19 to <i>Mar 27</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Mar 27</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <i>Michael Bryerly</i>			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Michael Bryerly</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>4-1-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Road-21206</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 3592
1. NAME OF DECEASED (Type or Print) <i>Pauline Yonko</i>		2. DATE AND HOUR OF DEATH <i>3/31/68 11:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital</i> <i>38</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>57-00</i> C. CITY OR TOWN <i>Cecil Co</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 25, 1882</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>AUSTRIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Peter Smutnicka</i>		14. MOTHER'S MAIDEN NAME <i>Mary NO INFO</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Michael Yonko (son) Chesapeake City, Md.</i>	
18. <i>560.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>SHALL BOWEL OBSTRUCTION</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ASCES</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>570.5 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/31</i> 19 <i>68</i> to <i>3/31</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3/31</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>F. M. Sandiford</i>		23B. DATE SIGNED <i>3/31/68</i>		23C. PHYSICIAN'S NAME (Type) <i>F. M. SANDIFORD, MD.</i>	
23D. ADDRESS <i>UNIVERSITY HOSPITAL</i>		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-4-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Rose of Lima Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Chesapeake City, Cecil, Md.</i>		25A. DATE REG'D BY HEALTH DEPT. <i>APR 2 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Sandiford</i>		25C. FUNERAL DIRECTOR <i>PIPPIN FUNERAL HOME</i>			
25D. ADDRESS <i>Robert E. Sandiford, Elkton, Md.</i>					

V.S. 153

4-11-68

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3593	
BIRTH NO. <b>P-516</b>		68- 3593		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LOUISE S. PUMPHREY</b>		2. DATE AND HOUR OF DEATH <b>31 March 68 - 4:00 A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> <b>4-26-68</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1894</b> <b>30 Sept. 1894</b>		9. AGE (In years lost birthday) <b>73</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William H. Stinchcomb</b>		14. MOTHER'S MAIDEN NAME <b>Ida R. Wheeler</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Thomas H. Pumphrey - Same as # 4</b>	
18. <b>398X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>416X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Rheumatic Heart Infection</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald M. Woods, MD</b>		23B. DATE SIGNED <b>3/31/68</b>		23C. PHYSICIAN'S NAME (Type) <b>Light Street Baltimore Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baldwin Memorial Ch. Ceme. Millersville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home/Glen Burnie, Md.</b>	

Prudential Ins. Co. Policy issued in 1918  
4-26-68 M.H. and V.S. 153

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		B-524 68-3594		CERTIFICATE OF DEATH		REG. NO. 68-3594	
1. NAME OF DECEASED (Type or Print) <b>BENSLEY, WILLIAM THOMAS</b>				2. DATE AND HOUR OF DEATH <b>MARCH 29 1968 10:10 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO, MD 21229</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Anne Arundel</b> C. CITY OR TOWN <b>LINTHICUM HGHTS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>517 DOGWOOD ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-03</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOVERNMENT WORK</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>JOHN J Bensley</b>				14. MOTHER'S MAIDEN NAME <b>GEORGIANNA CLARK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW1</b>			16. SOCIAL SECURITY NO. <b>213104562</b>		17. INFORMANT <b>WILKENS &amp; CATON AV BALTO MD 21229</b>		
18. <b>1989 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>metastatic ca to penis with urinary obstruction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>179.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <b>metastatic ca to penis with urinary obstruction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>179.0 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 13 19 68</b> to <b>MARCH 29 19 68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>MARCH 29 19 68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <b>Oscar Laborda</b> DEGREE						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>OSCAR LABORDA</b> DEGREE				23D. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO, MD 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Nat'l Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Oscar Laborda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Singleton Funeral Home/Glen Burnie, Md.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3595</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <u>BABY GIRL B.G. Geritz</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>3-31-68</u> <u>2:35 A</u> M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE CITY</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>6001 BELLONA AVE</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-30-68</u>		<b>9. AGE</b> (In years last birthday) <u>19</u> <b>Months</b> <u>43</u> <b>Days</b> <u>19</u> <b>Hours</b> <u>43</u> <b>Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<b>13. FATHER'S NAME</b> <u>WILLIAM GERITZ</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>PATRICIA LALLY</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT ADDRESS</b>	
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                              (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <u>Respiratory Distress Syndrome</u></p> <p><b>ANTECEDENT CAUSES</b>                              DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Immaturity</u></p> </div> <div style="width: 35%;"> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <u>19 hrs</u></p> </div> </div>					
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <u>773.5 II</u>					
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>Yes</u>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <u>No</u>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <u>3-30-68</u> 19 to <u>3-31-68</u> 19, that (I) (we) last saw the deceased alive on <u>3-31-68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Arthur L. BeauDET MD</u>				<b>23B. DATE SIGNED</b> <u>3-31-68</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>ARTHUR L. BEAUDET</u>				<b>23D. ADDRESS</b> <u>THE JOHNS HOPKINS HOSPITAL</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>CREMATION</u>		<b>24B. DATE</b> <u>4-1-68</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>JOHNS HOPKINS HOSPITAL</u>	
<b>24D. LOCATION</b> (City, town, or county) <u>BALTIMORE, MARYLAND</u>		<b>24E. STATE</b> <u>21205</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>APR 2 1968</u>	
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Fadden MD</u>		<b>25C. FUNERAL DIRECTOR ADDRESS</b> <u>HOSPITAL DISPOSAL</u>			



1228183  
CAMPBOR, WILBUR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-576		68- 3596		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3596	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>CAMPBOR, WILBUR</b>				3/31/68 16:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>				A. STATE <b>MARYLAND</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>N</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH <b>11-25-10 57</b>		9. AGE (In years) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Fitter</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. CITIZEN OF WHAT COUNTRY? <b>MD</b>	
13. FATHER'S NAME <b>HOWARD CAMPBOR</b>				14. MOTHER'S MAIDEN NAME <b>MARY K. BROWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-01-9099</b>		17. INFORMANT <b>EVELY CAMPBOR</b>	
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumococcal pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Mulhale myeloma</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Mulhale myeloma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>203X II</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/31 1968</b> to <b>3/31 1968</b> , that (I) (we) last saw the deceased alive on <b>3/31 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Zachary Grossman MD</b>				23B. DATE SIGNED <b>3/31/68</b>		23C. PHYSICIAN'S NAME (Type) <b>ZACHARY GROSSMAN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>4/4/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem PK</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Joseph L. Lock</b>	
24D. LOCATION (City, town, or county) <b>Arbutus, Md</b>				24E. ADDRESS <b>1304 N. Central Ave</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-3597</u>	
5-220 68-3597		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>PETE SAWCHUK</u>		2. DATE AND HOUR OF DEATH <u>4-1-68</u> <u>1 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Melchor Nursing Home</u> <u>2327 N. Charles St. Balto. 18, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO. MD.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>21230</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1885</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>American Sugar Co</u>	9. AGE (In years last birthday) <u>82</u>
13. FATHER'S NAME <u>Miron Sawchuk</u>		14. MOTHER'S MAIDEN NAME <u>(TAKA) unknown.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>219-09-6032</u>	
17. INFORMANT <u>Nephew - Walter Perkowski</u>		ADDRESS <u>2914 Kentucky Ave.</u>	
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarct - Instant.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> <u>Generalized Arteriosclerosis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Old CVA</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-18-1967</u> to <u>4-1-</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-1-</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Cesar Valle Caero</u>		23B. DATE SIGNED <u>4-1-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAERO</u>		23D. ADDRESS <u>8629 Liberty Rd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>APR 4 68</u>	24C. NAME OF CEMETERY or CREMATORY <u>HOLY TRINITY CFM.</u>	24D. LOCATION (City, town, or county) (State) <u>ELKRIDGE BALTO MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>	
25C. FUNERAL DIRECTOR <u>THE DIPPEL BROS INC 1800 E LOMBARD ST.</u>		ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3598

BIRTH NO. 64-27325

1. NAME OF DECEASED (Type or Print) <b>DARREN RENWICK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 31, 1968</b> Hour <b>3:20 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>HOPKINS HOSPITAL (DOA)</b> (If NOT in HOSPITAL or INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 31, 1968 3:20 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept 29/67</b>		10. AGE (In years last birthday) <b>3½</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>MATTIE LUCAS</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>WALTER Renwick 2433 E. Federal</b>	
19. CAUSE OF DEATH <b>485X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>481X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Adelphi, MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Ronald E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph J. Locks</b>		25D. ADDRESS <b>1301 N. Central</b>	

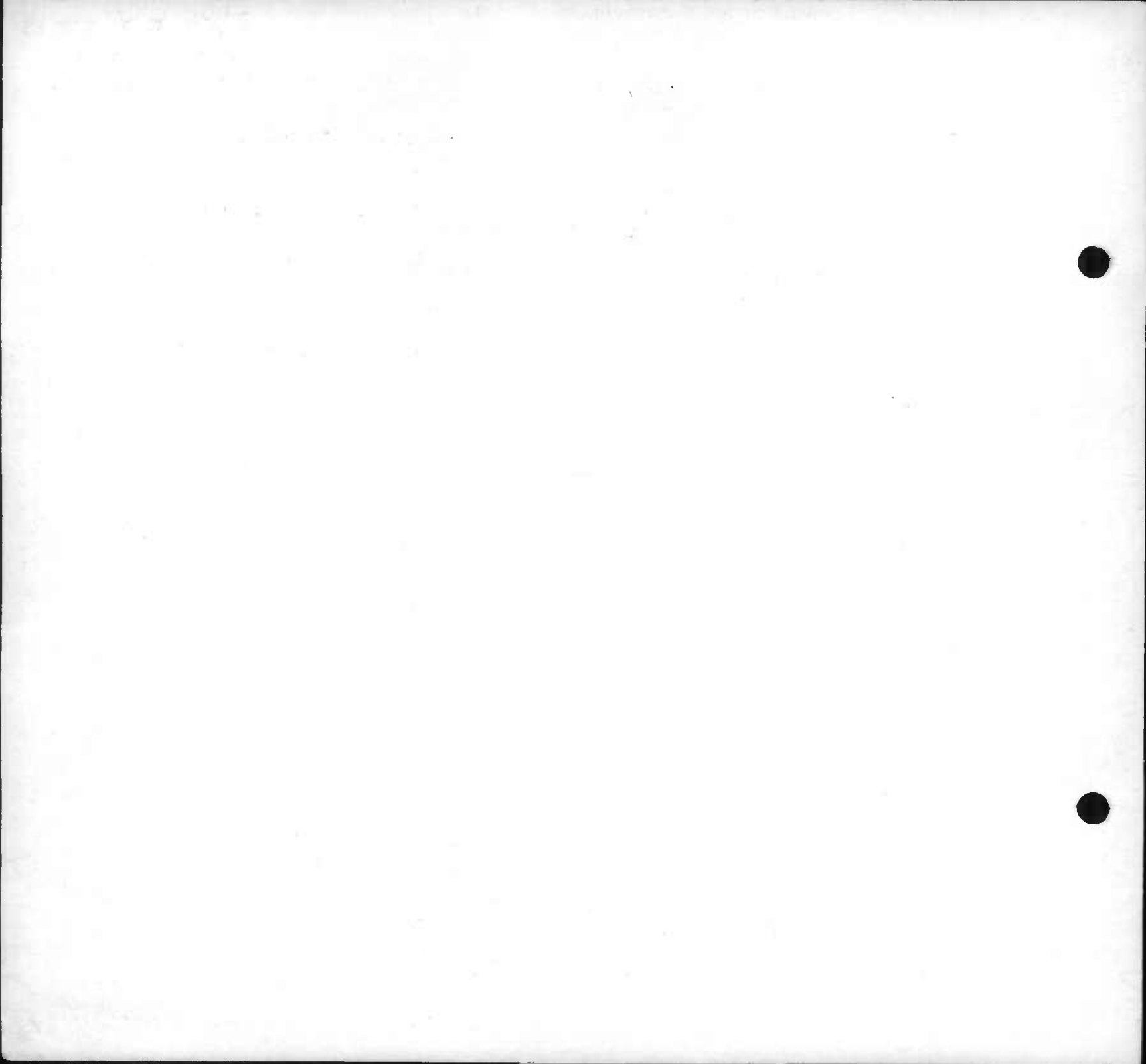
4-24-68

Called Funeral Director for correct age 3 1/2 yr. Birth 9-29-64  
5m.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3599</b>
68-3599 CERTIFICATE OF DEATH				COLE, CHARLES
BIRTH NO. <b>C-400</b>		1. NAME OF DECEASED (Type or Print) <b>COLE, Charles</b>		
2. DATE AND HOUR OF DEATH <b>3/26/68 5:15 a. M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>Maryland</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Johns Hopkins Hospital</b>		
6. SEX <b>Male</b> 7. RACE <b>Negroid</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>5/08/11</b> 10. AGE (In years last birthday) <b>56</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stevadore</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		
13. FATHER'S NAME <b>Lindsay Cole</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Harris</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-14-4710</b>		
17. INFORMANT <b>Family</b>		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertensive cardiac disease years</b>				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X II</b>				
21A. DATE OF OPERATION <b>0</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) <b>No</b>
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>68</b> to <b>3/26</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>G. M. Vincent</b>		23B. DATE SIGNED <b>3/26/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>G. M. VINCENT</b>		23D. ADDRESS <b>JOHNS HOPKINS Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 2, 1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>A. A. Co., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Robert Williams, 1701-03 N. Bond St. Balto. Md. 21203</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-520				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3600			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
JONES, Emanuel (NMT)				3/27/68 5:50 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY					
23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Maryland		C. CITY OR TOWN					
				Baltimore		D. INSIDE CITY LIMITS					
				E. STREET AND NUMBER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				1716 N. Durham Street							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.						
Male	Negriod	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/4/23	44							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					
Bandsaw Operator						Maryland					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?					
Robert Jones				Estelle Spriggs		U.S.A.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes 6-28-43 to 8-22-45				213-14-3289		Records VAH, 3900 Loch Raven Blvd, Balto., Md. 21218					
18. 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				Hypernephroma left kidney with metastasis to the liver, lungs, and mediastinum							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				Carcinomatosis, generalized							
(C) _____											
180X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)					
						NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 19 68 to March 27 19 68, that (we) last saw the deceased alive on March 27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE						23B. DATE SIGNED					
						March 27, 1968					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
ERNESTO SMITH, M.D.						3900 Loch Raven Blvd. Balto., Md. 21218					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)						
Burial		April 1, 1968	Balto. National Cemetery		Baltimore, Maryland						
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
APR 2 1968		Robert E. Farley, M.D.		Robert Williams, 1701-03 N. Bond St. Balto. Md.		21213					

CONFIDENTIAL (S)

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area. This information is being provided for your information and is not to be distributed outside of your office.

2. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILTON

FELDER

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

March 28, 1968

4:10 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1102 PEACH STREET

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 28, 1968

4:10 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Jul 2, 1931

10. AGE (in years  
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1308 S. Hanover Street

11. BIRTHPLACE (State or foreign country)

SE

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

GILBERT FELDER

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

CALLIE BALLARD

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Callie Ballard 1308 Hanover St

19. 011.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Pulmonary Tuberculosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-29-68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-1-68

24C. NAME of CEMETERY or CREMATORY

CARVER MEM. PARK

24D. LOCATION (City, town, or county)

LAUREL Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

25B. NAME OF REGISTRAR

R. E. Farley

25C. FUNERAL DIRECTOR

I. L. BROWN 123 W. MONTGOMERY ST.

ADDRESS

GUEST FOLDER  
CAME BARRY

21 1931

BURIAL 4-1-63 CARVER MEMORIAL PARK LAUREL MD

J. L. BROWN

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3602

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) EDNA

JONES

2. DATE  
OF DEATHKnown ☐  
Estimated ☐Month Day Year  
March 29, 1968Hour  
4:12 P.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL (DOA)

3. DATE  
PRONOUNCED DEADMonth Day Year  
March 29, 1968Hour  
4:12 P.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY6. SEX  
Female7. RACE  
Negro8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN  
BaltimoreD. INSIDE CITY LIMITS?  
YES ☐ NO ☐

9. DATE OF BIRTH

FEB 16, 1899

10. AGE (In years  
lost birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

817 Leadenhill Street

11. BIRTHPLACE (State or foreign country)

BALTO MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

GEORGE BARNES

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

HANNAH

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

MARIE NELSON 1629 BOOKER CT.

19.

412.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
No22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-3-68

24C. NAME of CEMETERY or CREMATORY

MOUNT CALVARY

24D. LOCATION (City, town, or county)

ARUNDEL Co. Md

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

I. L. Brownson 123 W. MONTGOMERY ST.

ADDRESS

Feb 16, 1929  
BAPT. MCH.

GEORGE BARNES  
HANNAH

MARIE WILSON 1624 BUCKLE CT

Wm. H. Kelly

BURIAL #3-68 Mount CARMEL Alexander Co. Md.  
The Brethren 1331 Montrose St.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-- 3603

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES BAILEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <b>March</b> Day <b>30</b> Year <b>1968</b> Hour <b>1:51</b> P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month <b>March</b> Day <b>30</b> Year <b>1968</b> Hour <b>1:51</b> P. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept 19 1909</b>		10. AGE (In years lost birthday) <b>58</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Bailey</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police</b>	
15. MOTHER'S MAIDEN NAME <b>Carrie Wilson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES</b>	
17. SOCIAL SECURITY NO. <b>28-01-0130</b>		18. INFORMANT <b>Denny L Wilson</b>	
19. <b>412.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. <b>422.1</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Roland N. Kornblum</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3-31-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>4-3-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Vernon Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		ADDRESS <b>1204 Milton Ave</b>	

1944

43-02-28 LB

100-200

68-3604

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68-3604

## BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

MACK, FRANKLIN

## 2. DATE AND HOUR OF DEATH

3/30/68

8:15:15 PM

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

31 BALTIMORE CITY HOSP.

4940 EASTERN AVENUE E

BALTIMORE, MARYLAND #21224

## 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MD. BALTIMORE

C. CITY OR TOWN BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2014 ASHLAND AVE. #21205

## 5. SEX

MALE

## 6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

8-10-27

## 9. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs.

Months: Days Hours: Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

## 10B. KIND OF BUSINESS OR INDUSTRY

None

## 11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

MACK, FRANKLIN

## 14. MOTHER'S MAIDEN NAME

ROSA LEWIS

## 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS  
4940 EASTERN AVE., BALTO, MD. #21224

## 18. 153.0 I

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

## CAUSE OF DEATH

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cystadenocarcinoma of

## (B) DUE TO, OR AS A CONSEQUENCE OF:

- appendix wide spread metastases

## (C) DUE TO, OR AS A CONSEQUENCE OF:

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Oct 1, 1966

## 153.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Colonic Carcinoma metastases

## 19A. DATE OF OPERATION

## 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 20A. AUTOPSY? (Yes or No)

NO

## 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

## 21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

## 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30/68 19 68 to 3/30/68 19 68, that (I) (we) lost saw the deceased alive on 6:30 pm 3/30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

## 23A. SIGNATURE

David Juan

M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

## 23B. DATE SIGNED

3/30/68

## 23C. PHYSICIAN'S NAME (Type)

DAVID JUAN, M.D.

## 23D. ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224  
BALTIMORE CITY HOSPITALS

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

4-3-68

## 24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cem

## 24D. LOCATION (City, town, or county) (State)

Balto

Md

## 25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

## 25B. NAME OF REGISTRAR

Rene E. Fajana

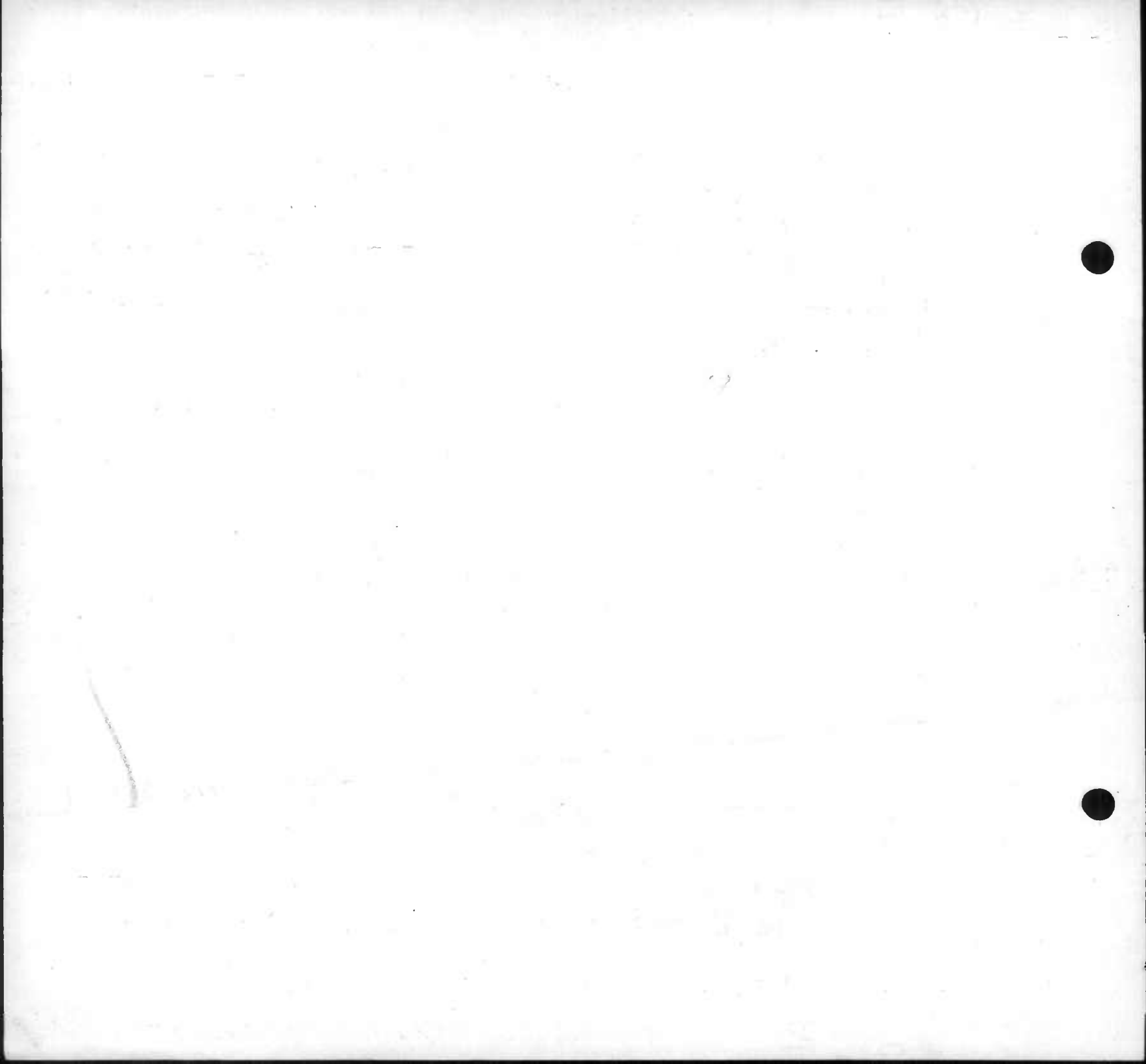
## 25C. FUNERAL DIRECTOR

Shay Wilson 1000 Brantley Rd

## ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
P-400

68- 3605

BALTIMORE CITY HEALTH DEPARTMENT

68- 3605

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALFRED POWELL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> 3:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION OR INSTITUTION <b>417 Forrest Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 29, 1968</b> 3:25 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>MAR. 15, 1919</b>		10. AGE (In years last birthday) <b>49</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Rockingham N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		E. STREET AND NUMBER <b>417 Forrest Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labr</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>Henry Powell</b>	
15. MOTHER'S MAIDEN NAME <b>Florence Mc Rae</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Watkins, King J Bone</b>		18. ADDRESS <b>North Carolina</b>		19. <b>571.8</b> CAUSE OF DEATH <b>Bronchopneumonia</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty Metamorphosis of Liver</b>	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Partial</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-30-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Rockingham</b>	
24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Watkins King J Bone</b>		25D. ADDRESS <b>North Carolina</b>			

Handwritten text, possibly a signature or name, appearing in the upper left quadrant.

Handwritten signature or name, appearing in the lower right quadrant.

R-534

68-- 3606 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3606

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LILLIAN RANDOLPH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 31, 1968</b> Hour <b>7:30 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>3919 Main Avenue</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>March 31, 1968</b> Hour <b>8:20 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>12-17-1886</b>		10. AGE (in years lost birthday) <b>82</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war, dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-01-6240</b>	
18. INFORMANT <b>Lillian Randolph</b>		ADDRESS <b>Same</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-22-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>Chas. Wilson</b>		ADDRESS <b>1001 Summit St</b>	

الشيخ محمد بن عبد الله

الشيخ محمد بن عبد الله

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3607

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ashley T. Powell</u>		2. DATE AND HOUR OF DEATH <u>April 2 1968</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: reside) A. STATE <u>Maryland</u> B. COUNTY _____	
FULL NAME OF HOSPITAL OR INSTITUTION <u>2407 Guilford Ave.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2407 Guilford Ave</u>					
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1905</u>	9. AGE (In years last birthday) <u>63</u>	10. If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Charles Powell</u>		14. MOTHER'S MAIDEN NAME <u>Sally Ann ?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Powell Same</u>	
18. <u>1519 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>151X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>L</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> 19 <u>67</u> to <u>April</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED <u>4-2-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>F.C. Caquin, M.D.</u> DEGREE				23D. ADDRESS <u>336 E. 25th. St. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Auburn</u>	
24D. LOCATION <u>Balto.</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>Sherry Wilson 1000 Broadway Ave</u>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

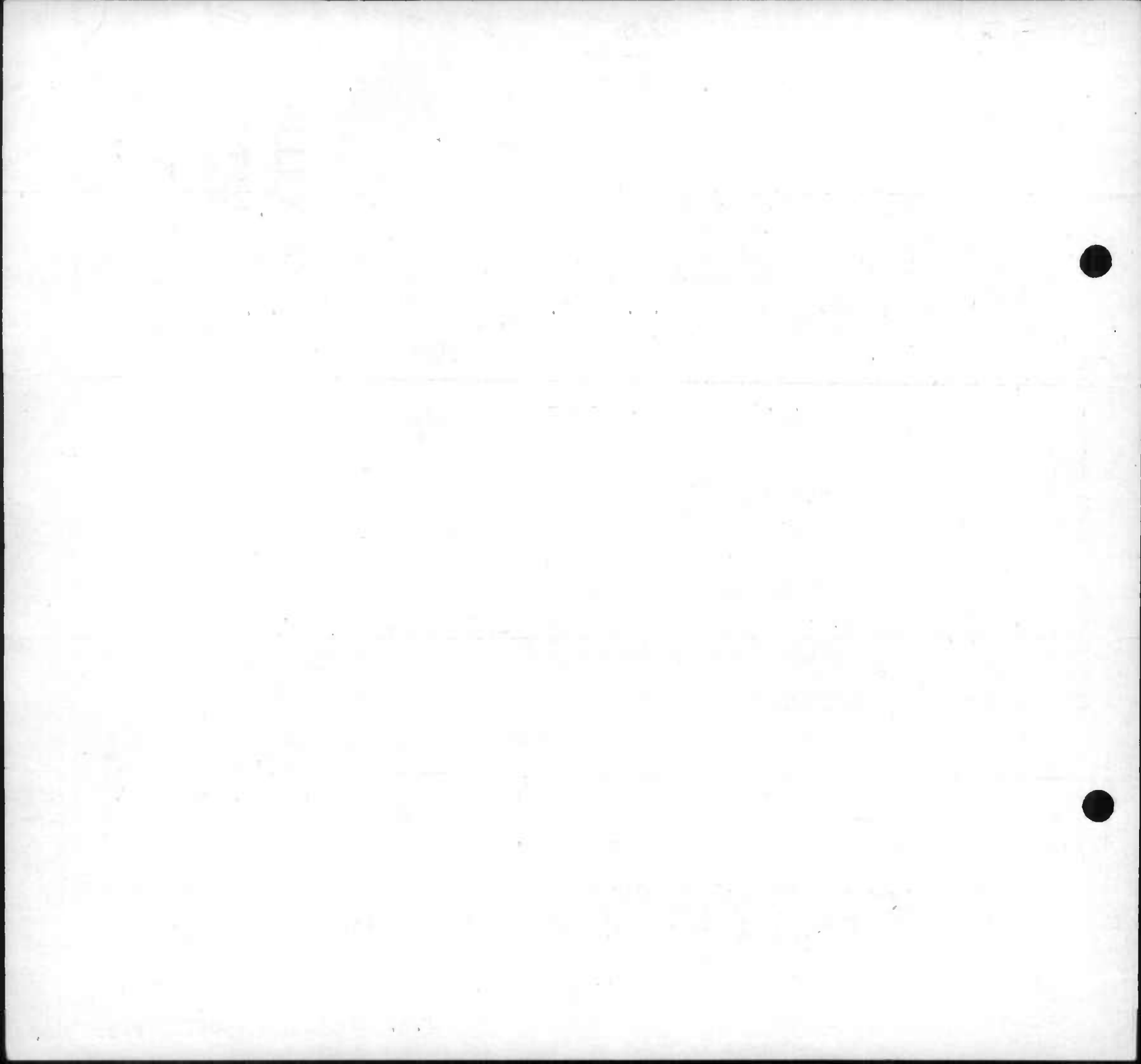
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3608

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3608

1. NAME OF DECEASED (Type or Print) <b>Henry L. Endress</b>		2. DATE AND HOUR OF DEATH <b>Mar. 30 68</b> <b>330 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Mem Hosp</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-34</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5411 Creston Ave.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1911</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	9. AGE (In years last birthday) <b>56</b>
11. BIRTHPLACE (State or foreign country) <b>Philipsburg N.J.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Geo.</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hofschild</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.2</b>		16. SOCIAL SECURITY NO. <b>572-03-4108</b>	17. INFORMANT <b>Wife</b>
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Acute coronary occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>	
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Hypertensive CVD</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 49</b> to <b>Mar. 30, 19 68</b> , that (I) (we) last saw the deceased alive on <b>March 30, 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Donald Jandorf</b>		23B. DATE SIGNED <b>3-30-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald Jandorf</b>		23D. ADDRESS <b>6077 Harford Rd</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/68</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>SHRINE Cem</b>		24D. LOCATION (City, town, or county) (State) <b>EASTON PA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jandorf</b>	
25C. FUNERAL DIRECTOR <b>P.A. Heemann</b>		ADDRESS <b>6067 Harford Rd.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68-3609 CERTIFICATE OF DEATH

REG. NO. 68-3609

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA E. MACK

2. DATE AND HOUR OF DEATH

March 29, 1968

12:30 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

House in the Pines - Belaire  
5837 Belair Rd.  
Balto., 21206, Md.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

417 S. Cornwall St. # 21224.

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Sept. 6, 1896

9. AGE (In years last birthday)

71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Adair

14. MOTHER'S MAIDEN NAME

Elizabeth Fidgett

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Myrtle A. Dundlow : 417 S. Cornwall St.

18.

412.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Circulatory Collapse

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 hours

(B) Anterograde Heart Disease

DUE TO, OR AS A CONSEQUENCE OF:

years

(C)

Repeated bouts of pneumonia  
Parkinson's Disease

6 mos.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from

thot (I) (~~we~~) lost saw the deceased alive on

and hour and from the causes stated above. (I) (~~we~~) (~~did~~) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

ALBERT B. BRADLEY

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/1/68

23D. ADDRESS

4900 Belair Rd., Balto., 21206, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-2-68.

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

7225 Eastern Blvd. Ba. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

25B. NAME OF REGISTRAR

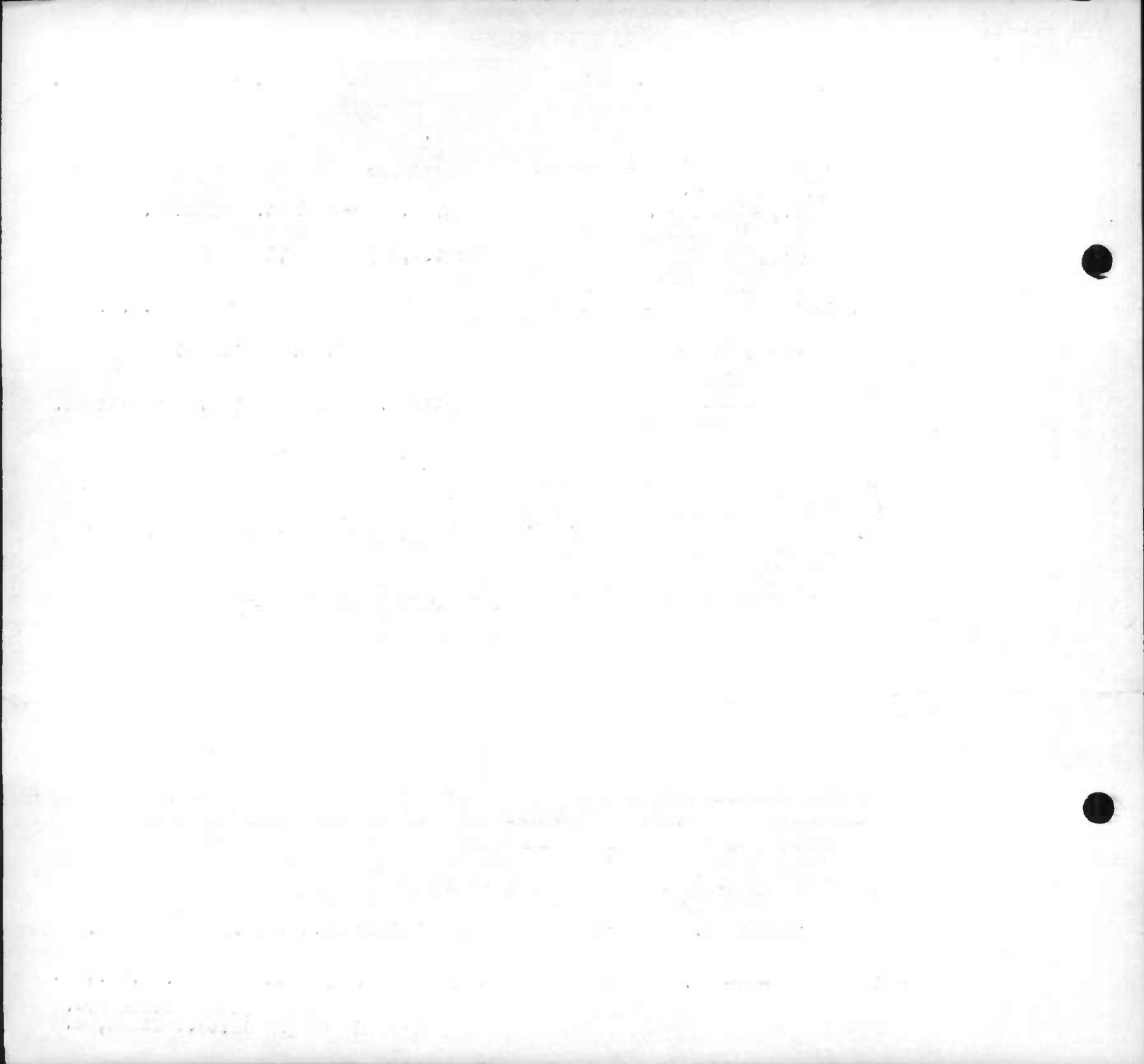
Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Charles S. Zeiler

25D. ADDRESS

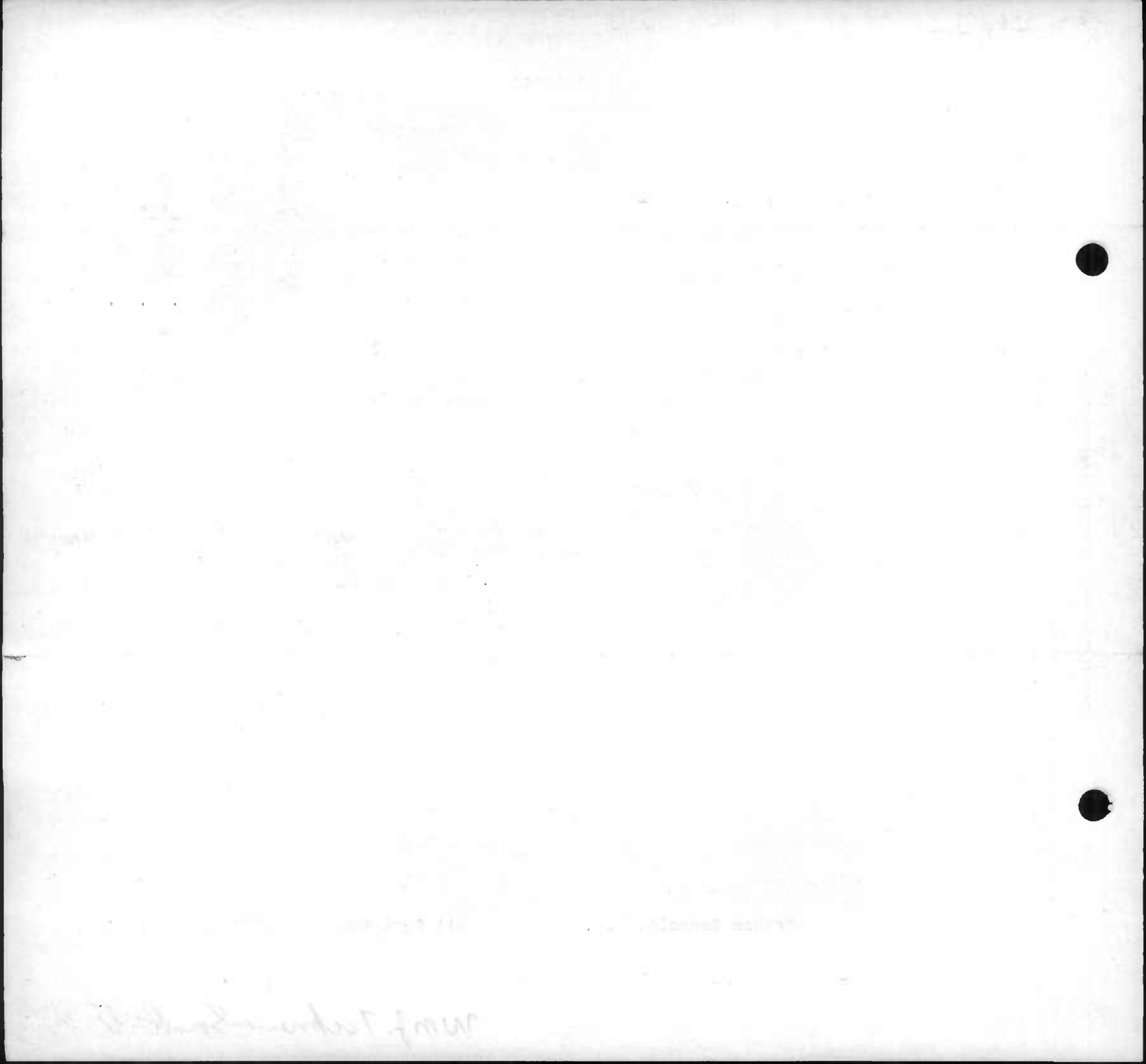
6224 Eastern Ave. Balto., 21224, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">68- 3610</span>	
1. NAME OF DECEASED (Type or Print) <b>Fannie Pokrass</b>		2. DATE AND HOUR OF DEATH <b>April 1, 1968</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>6007 Yorkwood Road Baltimore, Md. 21212</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6007 Yorkwood Road 21212</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1884</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Simon Whitcop</b>		14. MOTHER'S MAIDEN NAME <b>?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Mary Polk same address as above</b>			
18. <b>183.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA OF OVARY with metastasis to peritoneum, liver, lungs &amp; brain</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CARCINOMA OF OVARY with metastasis to peritoneum, liver, lungs &amp; brain</b>		(C) <b>9 months</b>			
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic cv disease</b>							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 65</b> to <b>31 march</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>31 march</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Abraham Genecin M.D.</b>						23B. DATE SIGNED <b>2 April 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Abraham Genecin, M.D.</b>		23D. ADDRESS <b>611 Park Avenue, Baltimore, Md. 21201</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial- Removal 4/1/68</b>		24B. DATE <b>4/1/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Towanda, Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tschuyra</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Tichner &amp; Sons</b>		ADDRESS <b>Baltimore, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-3611</span>
68-3611				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lewis Chester O'Dell</i>		2. DATE AND HOUR OF DEATH <i>9:30 pm 3/30/68</i> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Pa</i> B. COUNTY <i>V-35</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Miss Public Health Hospital</i>		C. CITY OR TOWN <i>Dittsburg</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>Main Street</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/16/1909</i>	9. AGE (In years last birthday) <i>58</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Personnel Analyst</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>George S. Odel</i>		14. MOTHER'S MAIDEN NAME <i>Mae Smith</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1943-1945</i>		16. SOCIAL SECURITY NO. <i>021-09-8198</i>		17. INFORMANT <i>Patient</i>
18. <i>194.0 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Metastatic Carcinoma of the Adrenal Gland</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>		
19. <i>195.0 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(it)</del> (this hospital) attended the deceased from <i>2-22-68</i> 19 to <i>3-30-68</i> 19, that <del>(it)</del> (we) last saw the deceased alive on <i>3-30-68</i> 19 and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(it)</del> (We) (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <i>Henry S. Crist, MD</i>		23B. DATE SIGNED <i>3/31/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Henry S. Crist</i>
23D. ADDRESS <i>USPHS Hospital</i>				
24A. BURIAL CREATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-3-68</i>		24C. NAME OF CEMETERY <i>IOOF CEM.</i>
24D. LOCATION (City, town, or county) (State) <i>BERLIN PA.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>APR 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Tashman</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Tashman &amp; Sons Baltimore</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.	
CERTIFICATE OF DEATH				WEG. NO.	
1. NAME OF DECEASED (Type or Print) <b>James E. Hand Sr.</b>			2. DATE AND HOUR OF DEATH <b>Apr. 1, 1968</b> <b>4:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>2231 Riggs Ave.</b>		
5. SEX <b>m</b>	6. RACE <b>w.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-86</b>		9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clifton Hand</b>			14. MOTHER'S MAIDEN NAME <b>Emma Davis</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-1808</b>		17. INFORMANT ADDRESS <b>Mrs. Carrie Hand, Balto., Md. 21216</b>	
18. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolism</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CVA</b> <b>ASCVP</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVP</b>		
19. DATE OF OPERATION <b>422.1 II</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that <del>at</del> (this hospital) attended the deceased from <b>Mar. 14</b> 19 <b>68</b> to <b>Apr. 1</b> 19 <b>68</b> , that <del>at</del> (we) last saw the deceased alive on <b>Apr. 1</b> 19 <b>68</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>We</del> (We) (did) ( <del>did not</del> ) view the body after death.			20A. AUTOPSY? (Yes or No) <b>No.</b>		
23A. SIGNATURE <b>Camilo C. Balacuit</b>			23B. DATE SIGNED <b>4/1/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>Camilo Balacuit, M.D.</b>			23D. ADDRESS <b>1213 Light St.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Avenue</b> <b>Witzke Funeral Directors, Balto., Md. 21229</b>			

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Emmeline Davis

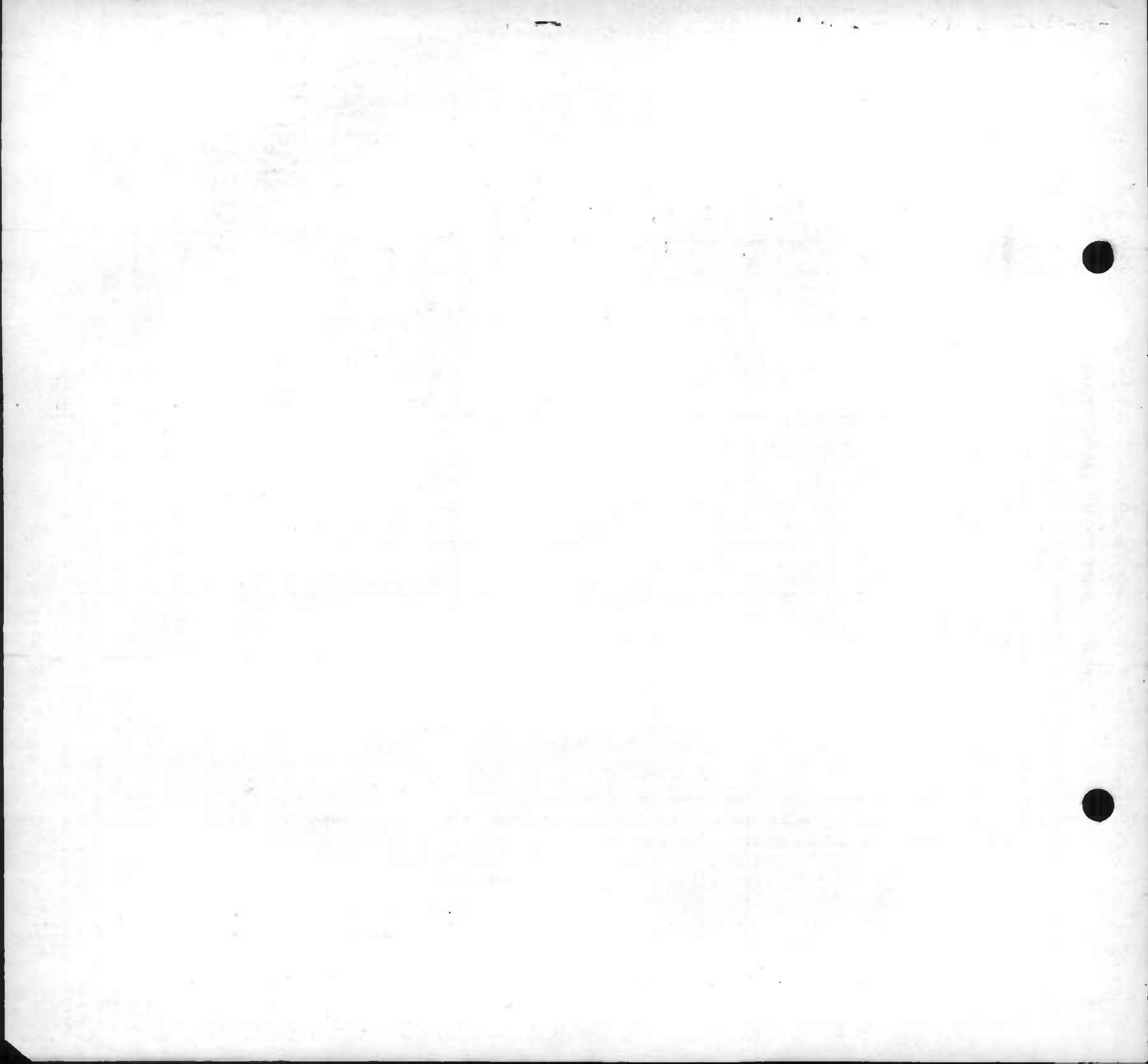
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Carrie Patterson, 90  
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BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Theresa Mc Nabbs</i>		2. DATE AND HOUR OF DEATH <i>3-26-68</i> <i>8 PM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital #</i> <i>4940 Eastern Ave. Baltimore, Maryland 21224</i>			C. CITY OR TOWN <i>Baltimore</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>3704 E. LOMBARD ST</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-54</i>	9. AGE (In years lost birthday) <i>9</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Paul McNabb</i>			14. MOTHER'S MAIDEN NAME <i>Rose Farrell</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH: Records 4940 Eastern Ave. Baltimore, Md.</i>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>E890 XI</i> <i>Respiratory insufficiency</i> <i>Brain anoxia</i> <i>Smoke inhalation</i> <i>Fire</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 hr.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>HOME</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>3704 E. Lombard St 26-08</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>MARCH 26 68 4:00 am</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Fire (Cause undetermined)</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>4:00 am 3-26 1968</i> to <i>8 PM 3-26 1968</i> , that (I) (we) last saw the deceased alive on <i>3-26-68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Quintero</i>				23B. DATE SIGNED <i>3-26-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Francisco Quintero</i>				23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Maryland</i> <i>Baltimore City Hospital # 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>3/30/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak/Park Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>B. V. BROUSSARD</i>		25D. ADDRESS <i>2818 E. BALTO. MD.</i>			

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3614

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3614

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GRIMES, MINNIE FLORINE</b>		2. DATE AND HOUR OF DEATH <b>4-1-68 XXXX08M 12:20P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>40</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>99 S. COLLINS AVE. 21229</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-11</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Balto.</b>	
13. FATHER'S NAME <b>WILLIAM C. Gaines</b>		14. MOTHER'S MAIDEN NAME <b>ROACH Mary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-7390</b>		17. INFORMANT <b>ADMISSION SLIP</b>	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Coronary Thrombosis</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive - Cerebro-Vascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/1/68</b> <b>16 yrs</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>4-1</b> 19 <b>68</b> to <b>4-1</b> 19 <b>68</b> , that <del>XX</del> (we) lost saw the deceased alive on <b>4-1</b> 19 <b>68</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (we) (did) ( <del>XXXX</del> ) view the body after death.					
23A. SIGNATURE <b>Edith W. Johnson</b>				23B. DATE SIGNED <b>4/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>3432 Frederick Ave</b> <b>Balt. Md. Md 21229</b>				23D. ADDRESS <b>Balt. Md. Md 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 4, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View Cemetery</b>	
24D. LOCATION <b>Carroll Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab 3512 Frederick Ave. Balto. Md</b>			

04-12-11

CALLIOPHORE

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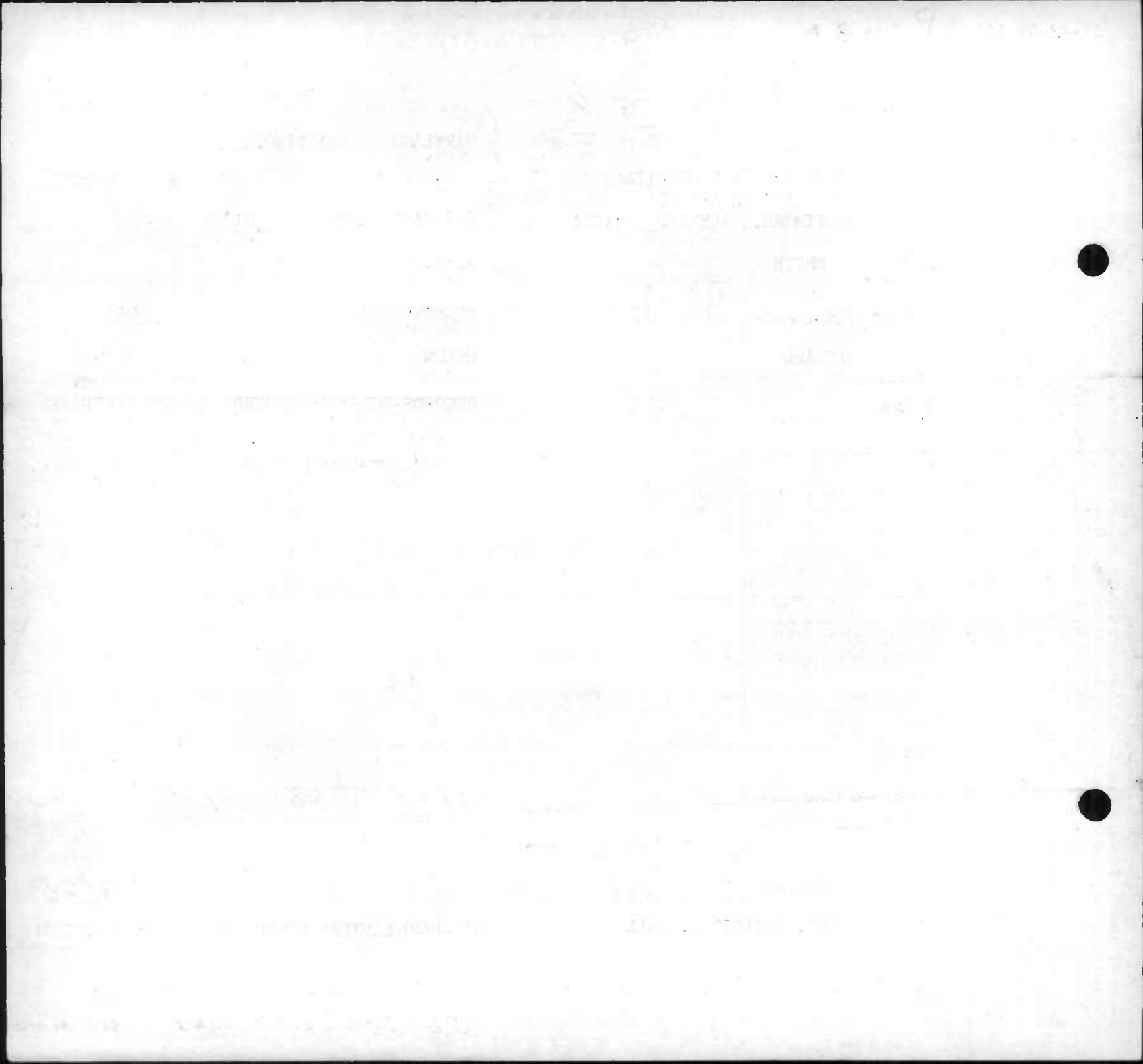
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 68- 3615				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3615	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
2. DATE AND HOUR OF DEATH				3-30-68 7:35 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE B. COUNTY MARYLAND BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN ESSEX			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER 305 MAPLE AVENUE 21221			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-29-09	
9. AGE (In years lost birthday) 58		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION				10B. KIND OF BUSINESS OR INDUSTRY STEEL			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MICHAEL				14. MOTHER'S MAIDEN NAME HELEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO.			
17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE				ADDRESS MD			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury at complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/30 1968 to 3/30 1968, that (I) (we) last saw the deceased alive on 3/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Phillip L. Hall				23B. DATE SIGNED 3/30/68		23C. PHYSICIAN'S NAME (Type) DR. PHILLIP L. HALL	
23D. ADDRESS BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224				23E. FUNERAL DIRECTOR J.G. CONNELLY SONS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/3/68		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1968		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 380 MACE	



## 68-3616 CERTIFICATE OF DEATH

REG. NO. 7

68-3616

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH M. SCHOLTZ

2. DATE AND HOUR OF DEATH

8:45 AM 3/30/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

53-00

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

309 ESSEX AVE

21224

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/1/94

9. AGE (In years  
last birthday)

74

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Anthony FREDERICK

14. MOTHER'S MAIDEN NAME

Minnie

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-22-6925

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

427.9 + 250.9  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

CAUSE OF DEATH

VENTRICULAR TACHYCARDIA -  
UNKNOWN ETIOLOGYAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 1/4 HOUR

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

434.2 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (the deceased) attended the deceased from 3/30 19 68 to 3/30 19 68,  
that (we) last saw the deceased alive on 3/30 19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

Marvin C. Mengel M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3/30/68

23C. PHYSICIAN'S  
NAME (Type)

MARVIN C. MENGEL M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

BALTIMORE CITY HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

4/2/68

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 3 1968 Robert E. Johnson

J.G. CONNELL &amp; SONS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THE UNIVERSITY OF

CHICAGO

DEPT. OF EDUCATION

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THE UNIVERSITY OF

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MARVIN C. MANDER

M.D. CHICAGO

CHICAGO

B-623

68-3617 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3617

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BRUCE BREWSTER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 31, 1968</b> 3:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CITY HOSPITAL (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 31, 1968</b> 3:55 A.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>MAY 23, 1927</b>		10. AGE (In years lost birthday) <b>40</b>		C. CITY OR TOWN <b>Baltimore ROSEDALE</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOOL MAKER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>MARTIN</b>		E. STREET AND NUMBER <b>914 Rosedale Avenue</b>	
15. MOTHER'S MAIDEN NAME <b>BERTHA THOMPSON</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNK</b>			
17. SOCIAL SECURITY NO. <b>412-30-6071</b>		18. INFORMANT ADDRESS <b>ETHEL BREWSTER ABOVE</b>			
19. CAUSE OF DEATH <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>E 816.4 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Route 40 and Middle River Road 53-00</b>	
22D. TIME OF INJURY (APPROX.) <b>3 31 68 2:57a</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver in auto-auto collision</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Roland N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Roland N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>3-31-68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>CREST LAWN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>J. E. CONNELLY SON 300 MACE</b>			

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68- 3618

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3618

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARGARET MARIE DASHIELLS

2. DATE AND HOUR OF DEATH

3-31-68 13:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

The Union Memorial Hospital

MD

C. CITY OR TOWN

E. STREET AND NUMBER

Baltimore 1100 Ramblewood Rd 212

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

5. SEX

F

6. RACE

W

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

5-08-11

9. AGE (In years  
last birthday)

56

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

MD Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William F. Walker

14. MOTHER'S MAIDEN NAME

Margaret Christ

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-48-5156

17. INFORMANT

Milton F. Dasheills 1100 Ramblewood Rd

ADDRESS

21212

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3-31-68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Brain Tumor

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-30-1968 to 3-31-1968,  
that (I) (we) last saw the deceased alive on 3-31-1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Felix J. Martin

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3-31-68

23C. PHYSICIAN'S  
NAME (Type)

DR. FELIX J. MARTIN

DEGREE

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-3-1968

24C. NAME OF CEMETERY or CREMATORY

Druid Ridge Cemetery

24D. LOCATION

Baltimore Co.

(City, town, or county)

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

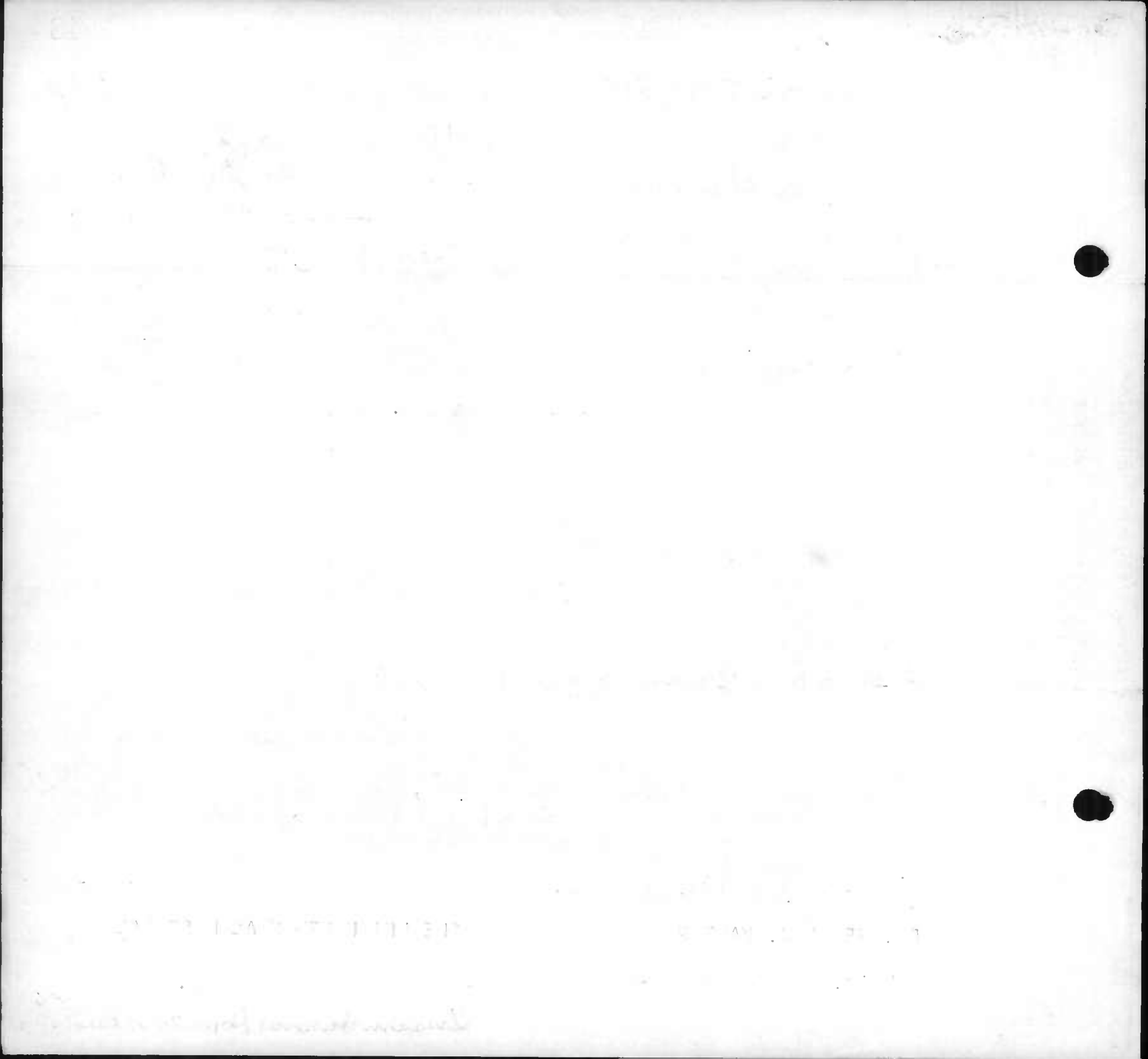
Lassahn Funeral Home 7401 Belair Road

ADDRESS

26

FUNERAL DIRECTOR: IMPORTANT

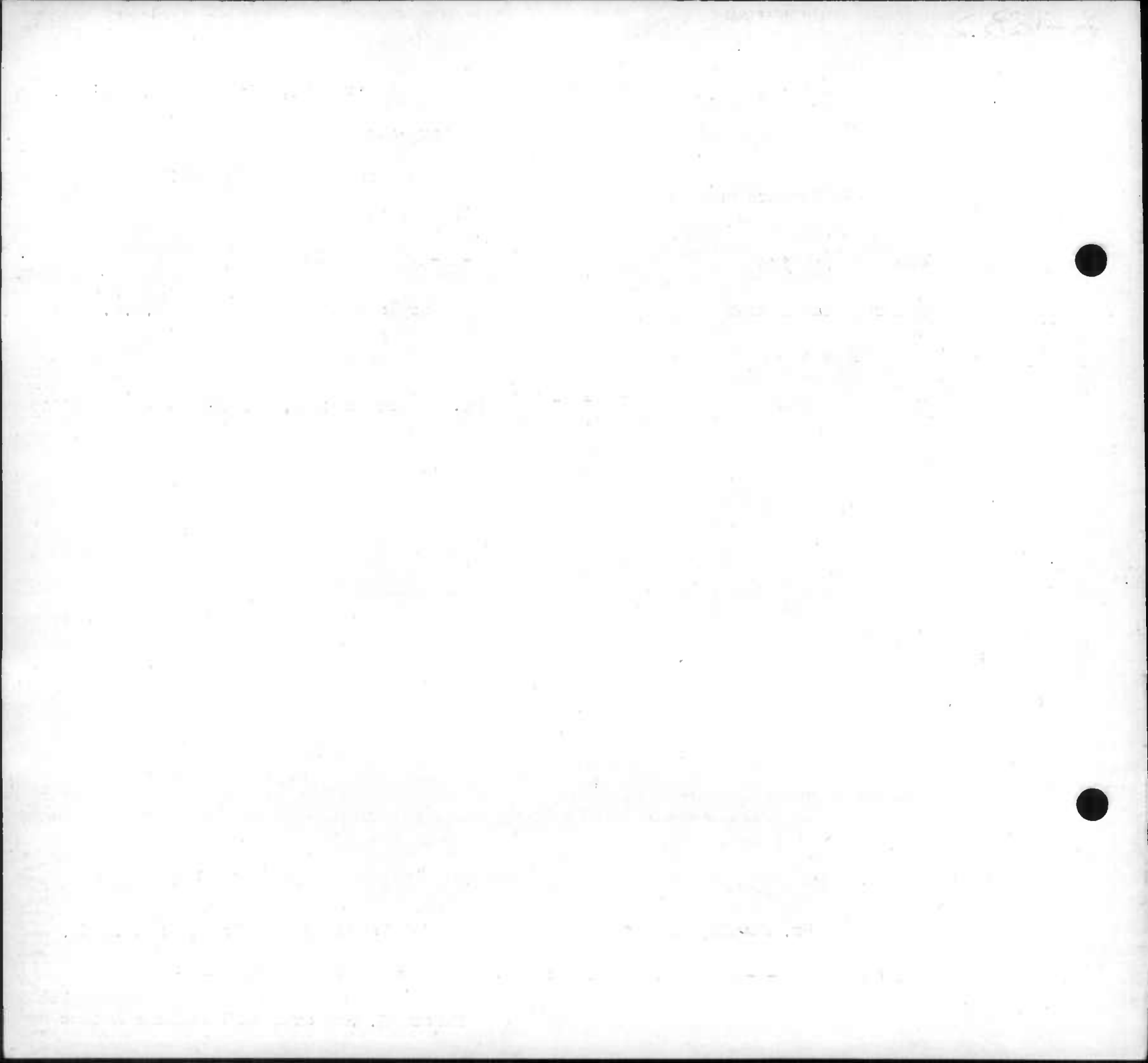
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DEWEY BRODSKY</b>		2. DATE AND HOUR OF DEATH <b>March 31, 1968 4:40 p M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>34 Bon Secours Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>17 04</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION		E. STREET AND NUMBER <b>1706 Wilkens Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-1898</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steamfitter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W 1</b>		16. SOCIAL SECURITY NO. <b>218-01-8707</b>		17. INFORMANT ADDRESS <b>Mr. Robert Brodsky, 775 Yale Avenue 21229</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Massive myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>An old myocardial infarct.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Massive myocardial infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>An old myocardial infarct.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>430.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>March 31 1968</b> , that (I) (we) lost saw the deceased alive on <b>March 31 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stanley Ankudas</b>				23B. DATE SIGNED <b>4.1.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Stanley Ankudas</b>		23D. ADDRESS <b>1101 Maiden Choice Lane, Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>	



FUNERAL DIRECTOR: IMPORTANT

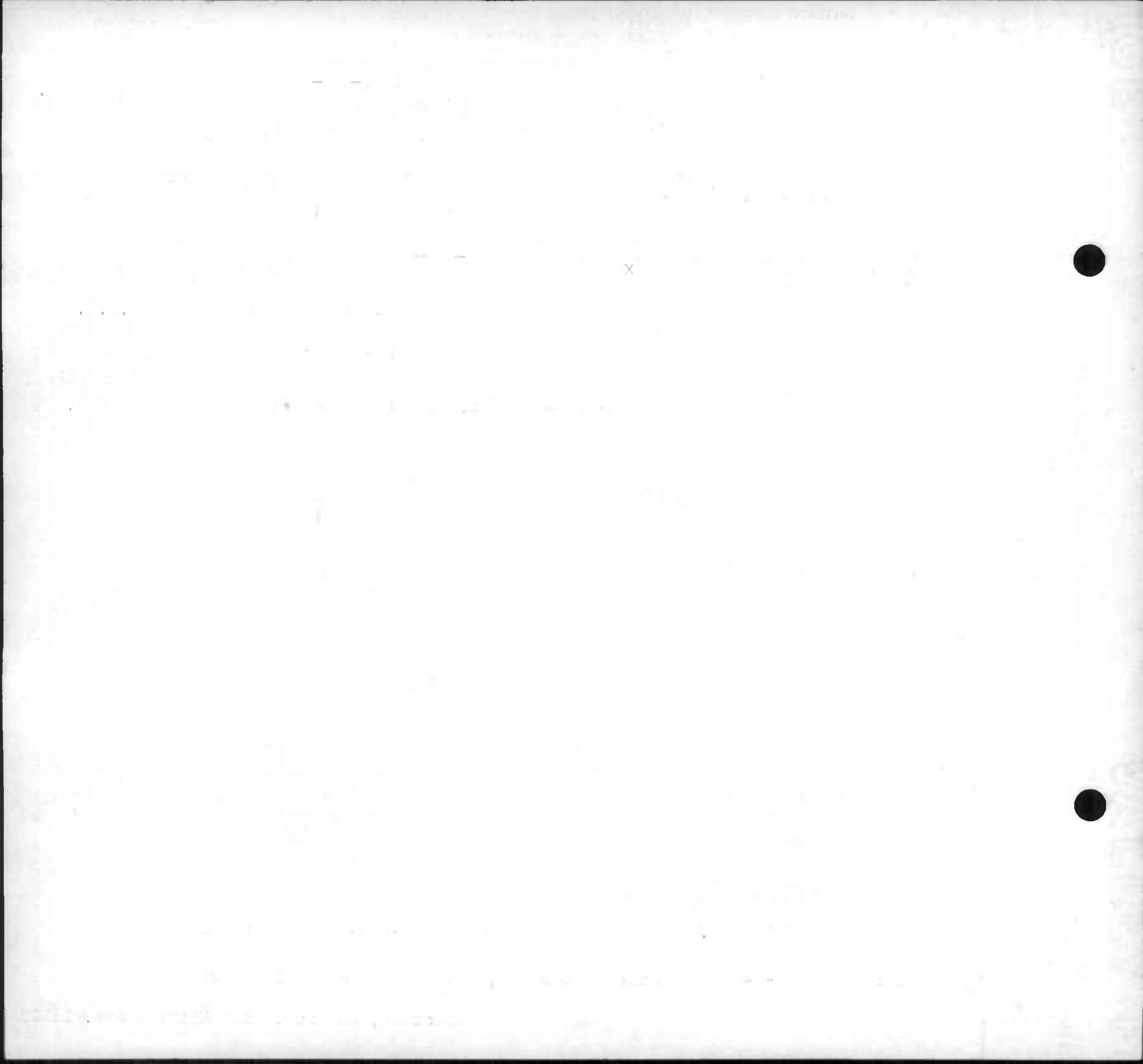
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3620

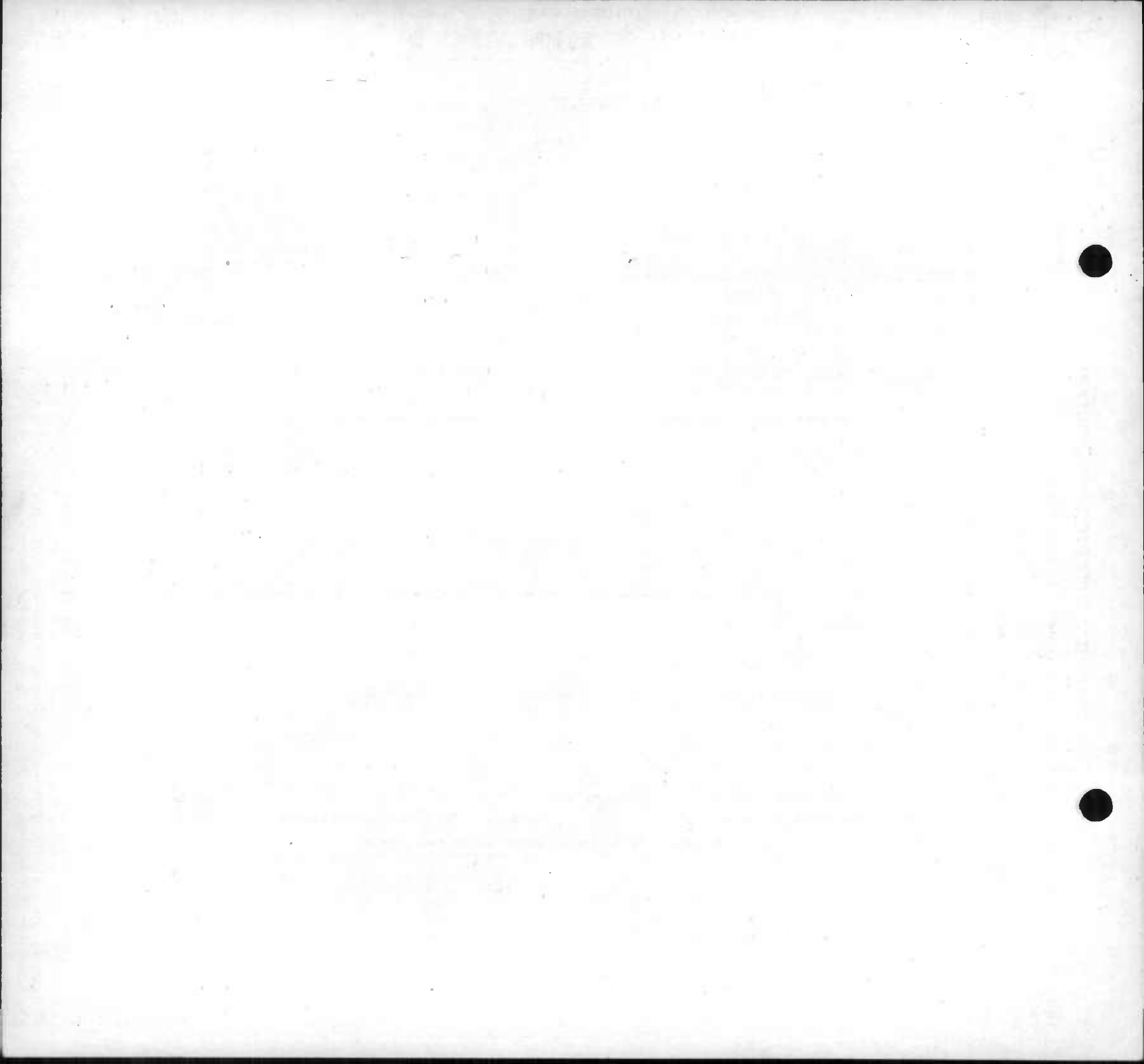
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELSIE M. ALEXANDER</b>		2. DATE AND HOUR OF DEATH <b>3-31-68</b>   <b>7:50 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8-14-83</b>		9. AGE (In years last birthday) <b>84</b>		10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SILAS TOWNSEND</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET PHELPS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-30-7296</b>		17. INFORMANT <b>Mr. William Alexander, 8 Mallow Hill Rd.</b> ADDRESS <b>21229</b>	
18. <b>5730 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic failure</b>				<b>5 mo</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hepatitis</b>				<b>Unknown</b>	
19. <b>583X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/20/68</b> to <b>3/31</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas C. Butler</b>				23B. DATE SIGNED <b>3/31</b>	
23C. PHYSICIAN'S NAME (Type) <b>THOMAS C. BUTLER</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-1968</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b> ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>II64 68-3621</u>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>B. BROADY, ALEXANDER</u>		2. DATE AND HOUR OF DEATH <u>3-30-68</u> <u>10:30 A.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>90 BOLTON HILL NURSING CENTER</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY/TOWNSHIP</u> C. CITY/TOWNSHIP <u>DEALE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>913 WINSTON AVE</u>		
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-89</u>	9. AGE (In years) <u>78 yrs.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NERO BROADY</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>237 38 4038</u>		17. INFORMANT <u>ADMISSION RECORD</u>		
18. <u>437.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral arteriosclerosis with cerebral vasculature</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years - 3/14/68</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>65</u> to <u>3/30</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3/30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>al [Signature]</u>		23B. DATE SIGNED <u>3/30/68</u>		23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-3-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Lake AME Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Gibson, N.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Kelson Funeral Home 1348 Calhoun St</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3622</u>
BIRTH NO.				68- 3622
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
LILLIE MAY DUNBAR		April 2, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>00</u> 2735 N. Calvert Street		A. STATE Maryland		
		C. CITY OR TOWN Baltimore		
		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 2735 N. Calvert Street		
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1887	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Rodehmar, West Virginia	
13. FATHER'S NAME Harmon Baker		14. MOTHER'S MAIDEN NAME Mary Klines		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 233-42-7649	17. INFORMANT Fike-Watson F.H.	
		ADDRESS Terra Alta, W.Va.		
18. <u>412.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hypertensive CV Disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>with CVA.</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
18. <u>443X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  7  7		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-25</u> 19 <u>51</u> to <u>4-2</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3-25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Samuel Legum</u>			23B. DATE SIGNED 4-3-68	
23C. PHYSICIAN'S NAME (Type) Dr. Samuel Legum			23D. ADDRESS 1261 East North Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-6-68	24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	24D. LOCATION (City, town, or county) (State) Preston County West Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1968		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.	
		ADDRESS 1217 St. Paul Street Balt., Md. 21202		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3623

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-3623

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AMELIA MAGRAUER

2. DATE AND HOUR OF DEATH

4-1-68

4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS

YES ☒

NO ☐

E. STREET AND NUMBER

4503 Hampnett Ave 21214

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

82  
9-17-88

9. AGE (In years  
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

PETER LAUTENKLOS

14. MOTHER'S MAIDEN NAME

BARBARA

Reming

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

DAUGHTER

ADDRESS

SAME AS #4

18. 206.0 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Broncho pneumonia

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ACUTE MONOCYTIC

LEUKEMIA

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Acute Monocytic Leukemia

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-28 1968 to 4-1 1968,  
that (I) (we) lost saw the deceased alive on 4-1 1968 and that in my (our) opinion death occurred on the date  
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D.H. BRANCATO, M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

4-1-1968

23C. PHYSICIAN'S  
NAME (Type)

D.H. BRANCATO, M.D.

23D. ADDRESS

UNION MEM. HOSP.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-4-1968

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

24D. LOCATION

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 3 1968

Wm. Cook-Brooks, Inc.

Wm. Cook-Brooks, Inc. Balto., Md. 21202

TO THE DIRECTOR, FBI

WASHINGTON, D.C.

SEP 12 1962

RE: [illegible]

9-12-62

MEMO

TO: DIRECTOR

FROM: SAC, NEW YORK

~~RE: [illegible]~~

Re: [illegible]

10

11

12

13

14

68- 3624

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68- 3624

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BYARD, William Patrick

2. DATE AND HOUR OF DEATH

4/1/68

3:32 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☐NO ☐

E. STREET AND NUMBER

945 Horner Lane

5. SEX

Male

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

4/16/82

9. AGE (In years  
lost birthday)

85

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Ship Caulker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John R. Byard

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215-09-0147

17. INFORMANT

ADDRESS

William Byard 945 Horner Lane

18. *E880X I*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.*E900.0 II*OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☒  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)*X HOME*21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

*945 Horner Lane 26-34*21D. TIME  
OF INJURY  
(APPROX.)*3-31-68 9:45 PM*

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☒

21F. HOW DID INJURY OCCUR?

*fell down steps*22. I certify that (I) (this hospital) attended the deceased from *1 APRIL 1968* to *1 APRIL 1968*,  
that (I) (we) last saw the deceased alive on *1 APRIL 1968* and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Merwyn Bagan*Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

*1 April 68*23C. PHYSICIAN'S  
NAME (Type)

Dr. Merwyn Bagan

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-4-1968

24C. NAME of CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

*APR 2 1968 R. A. E. Feltner*

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

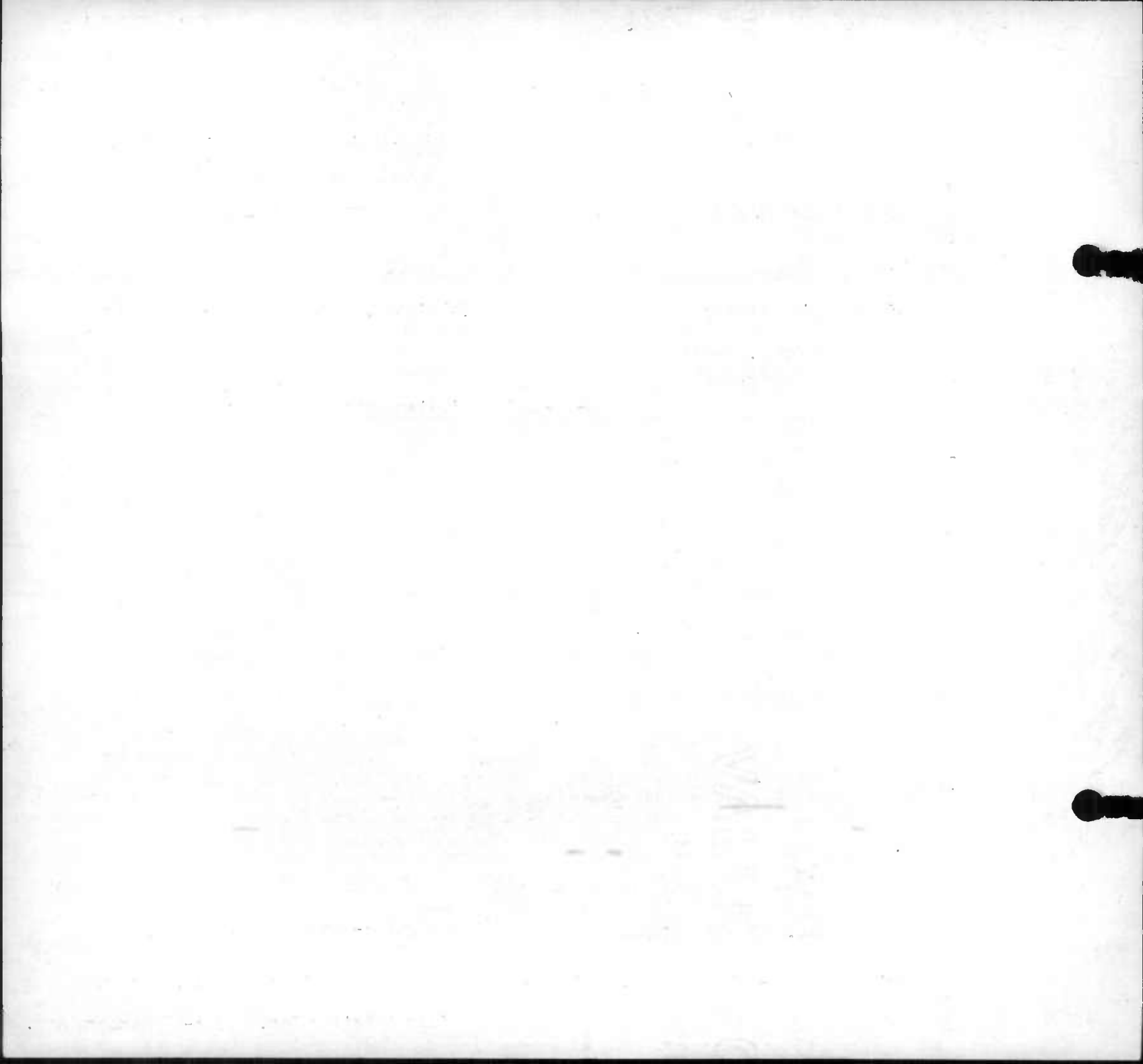
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released On Approval for the Medical Examiner's Office by Dr. Spitz

MEDICAL CERTIFICATION

CAUSE OF DEATH  
SUBDURAL HEMATOMA  
? 7 HOURS  
E900.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  
19A. DATE OF OPERATION  
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  
20A. AUTOPSY? (Yes or No)  
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
21D. TIME OF INJURY (APPROX.)  
21E. INJURY OCCURRED While At Work Not While At Work  
21F. HOW DID INJURY OCCUR?  
22. I certify that (I) (this hospital) attended the deceased from 1 APRIL 1968 to 1 APRIL 1968, that (I) (we) last saw the deceased alive on 1 APRIL 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  
23A. SIGNATURE  
23B. DATE SIGNED  
23C. PHYSICIAN'S NAME (Type)  
23D. ADDRESS  
24A. BURIAL CREMATION, REMOVAL (Specify)  
24B. DATE  
24C. NAME of CEMETERY or CREMATORY  
24D. LOCATION (City, town, or county) (State)  
25A. DATE REC'D BY HEALTH DEPT.  
25B. NAME OF REGISTRAR  
25C. FUNERAL DIRECTOR ADDRESS



F-400

68-3625 BALTIMORE CITY HEALTH DEPARTMENT

68-3625

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DENNIS F. FOLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>March 31, 1968</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>516 S. Duncan Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 2, 1968 8:56 A.M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>104</b>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 20, 1926</b>		10. AGE (In years last birthday) <b>41</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>516 S. Duncan Street</b>
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Patrick V. Foley</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinest</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Julia A. Twohig</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		17. SOCIAL SECURITY NO. <b>215-28-6888</b>		18. INFORMANT ADDRESS <b>Miss Julia Foley 516 S. Duncan Street</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/2/68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Springdale Catholic</b>	
24D. LOCATION (City, town, or county) (State) <b>Fayette County, West Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1968</b>		25B. NAME OF REGISTRAR <b>20-52. F. J. ...</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</b>					

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

Handwritten text, likely a signature or a line of text, mostly illegible.

Handwritten signature or name, possibly "William" or "William H. ...", written in cursive.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-3626			
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>John Scott 3626</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>													
1. NAME OF DECEASED (Type or Print) <u>JOHN J. HOYT</u>						2. DATE AND HOUR OF DEATH <u>April 2, 1968</u> <u>2:35 A.</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home &amp; Hospital</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>738 S. Curley St.</u>							
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-1902</u> <u>65</u>		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad worker</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Hoyt</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Finnerty</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-0991</u>		17. INFORMANT <u>J. Edward Hoyt</u>				ADDRESS <u>738 S. Curley Street</u>			
18. <u>492X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>527.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pericarditis</u>													
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>March 19</u> 19 <u>68</u> to <u>April 2</u> 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 2</u> 19 <u>68</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) (did not) view the body after death.													
23A. SIGNATURE <u>José S. Naigog</u> DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-2-68</u>			
23C. PHYSICIAN'S NAME (Type) <u>José S. Naigog</u> DEGREE								23D. ADDRESS <u>Church Home &amp; Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-5-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Schwartz</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>				25C. FUNERAL DIRECTOR <u>Lilly &amp; Zeiler Inc.</u>				ADDRESS <u>1901-07 Eastern Ave.</u>	

... ..

W

Woodward  
William Lloyd

Woodward  
William Lloyd  
282 S. ...

2-1405 42

Woodward  
William Lloyd

William Lloyd

Woodward

42

Woodward  
William Lloyd

William Lloyd

Woodward  
William Lloyd

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3627

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DAVID L. LATNEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> 11:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 29, 1968 11:30 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
13. FATHER'S NAME <b>Leon Latney</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Lillian</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>214-04-9267</b>		18. INFORMANT <b>Mr Lee Latney,</b> ADDRESS <b>2239 Aisquith St</b>	
19. <b>746.9</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Congenital Heart Disease</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3-30-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

Paul Miller

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3628

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MATTIE MOORE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 30, 1968</b> <b>11:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1730 N. Chester Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 30, 1968</b> <b>11:00 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3/4/1919</b>		10. AGE (In years lost birthday) <b>49</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Moore</b>		14. MOTHER'S MAIDEN NAME	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. HOW DID INJURY OCCUR?		28. AUTOPSY? (Yes or No) <b>No</b>	
29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3-31-68</b>			
29A. BURIAL CREMATION, REMOVAL (Specify) <b>Remove</b>		29B. DATE <b>April 3/68</b>	
29C. NAME OF CEMETERY or CREMATORY <b>Charter S. C.</b>		29D. LOCATION (City, town, or county) (State)	
29E. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		29F. NAME OF REGISTRAR <b>Robert E. Fairbanks</b>	
29G. FUNERAL DIRECTOR <b>Milton E. Erickson</b>		29H. ADDRESS <b>1129 N. Caroline St.</b>	

MAIL FILE

1944

1945

**FUNERAL DIRECTOR: IMPORTANT**  
ON APPROVAL BY DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE

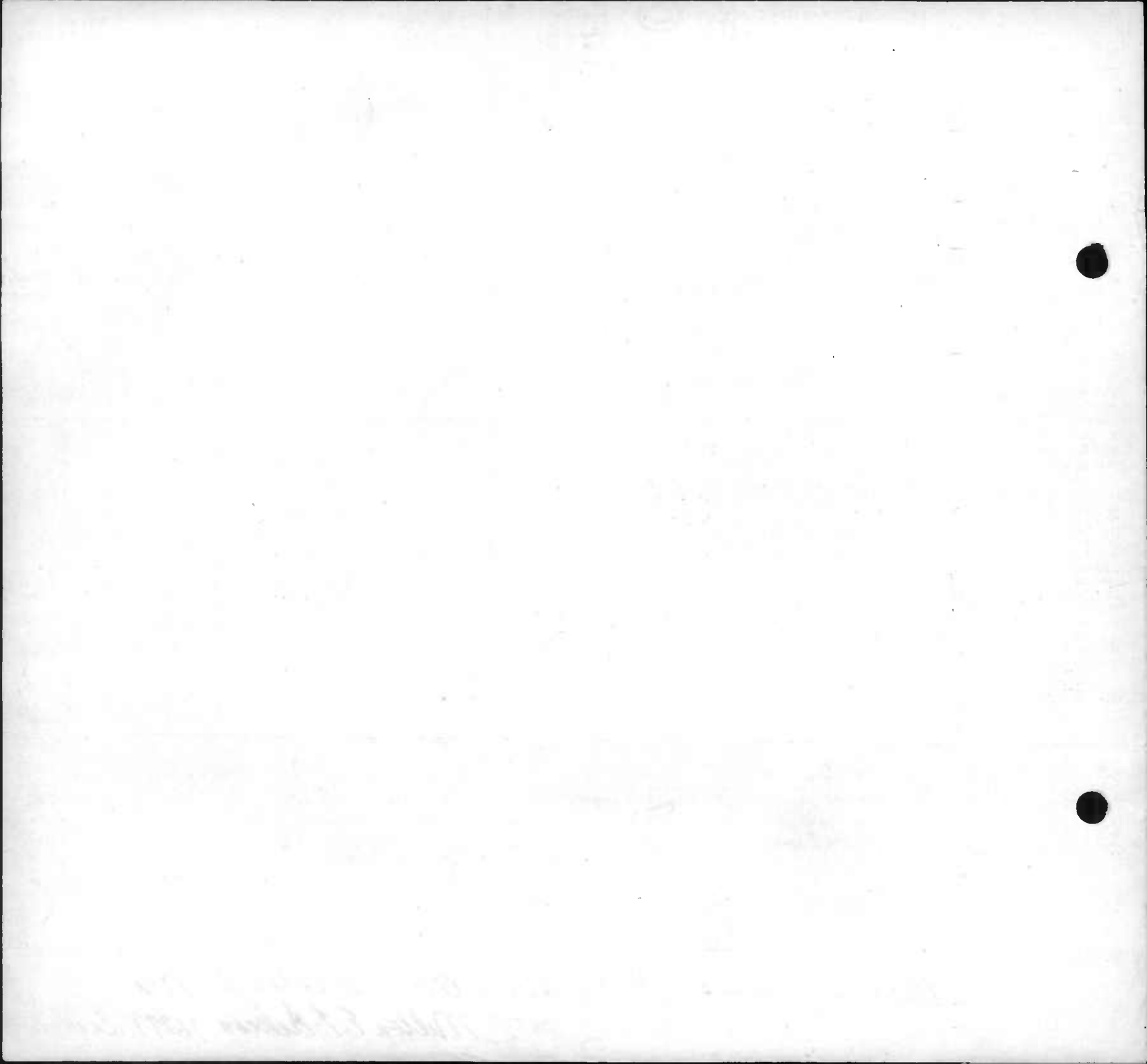
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE RELEASED ON APPROVAL BY DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3629

BIRTH NO. <b>A-536</b>		68-3629	
1. NAME OF DECEASED (Type or Print) <b>ROSALYN ANDERSON</b>		2. DATE AND HOUR OF DEATH <b>3/29/68 9:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY</b>	
5. SEX <b>F</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/31/54</b> 9. AGE (In years last birthday) <b>13</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>CALVIN ANDERSON.</b>		14. MOTHER'S MAIDEN NAME <b>DOROTHY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>CALVIN ANDERSON.</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E854.0</b> <b>PHEDOBARTITAL INGESTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) (B) (C) UNDERLYING CONDITION lost. <b>E871.6 II</b> <b>IRIDOPATHIC EPILEPSY</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>School</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Baltimore City</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>3 20 68</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Swallowed Her Epilepsy Pills</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3/20 1968</b> to <b>3/29 1968</b> , that (I) (we) last saw the deceased alive on <b>3/29 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>W E Bucknall</b>		23B. DATE SIGNED <b>3/29/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM E. BUCKNALL</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr 2/68</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>My Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Westport, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>Milton E. Erickson</b>		ADDRESS <b>1129 N. Calhoun</b>	



## CERTIFICATE OF DEATH

REG. NO.

68- 3630

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CORNELIUS LEMON

2. DATE AND HOUR OF DEATH

4/1/68 7:45 AM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Balt.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

3 South Lane # 21222 005 53-00

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1/7/16

9. AGE (In years  
lost birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Crane Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia, Gloucester Co., U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Cornelius E. Lemon

14. MOTHER'S MAIDEN NAME

Sadie Lemon

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

166-16-2088

17. INFORMANT

BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS

# 21224

18. 730.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last,

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Subarachnoid hemorrhage

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1/68 to 4/1/68.  
that (I) (we) last saw the deceased alive on 4/1/68 and that (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

M. Jaffee, MD.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4/1/68

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Maryland #2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-5-68

24C. NAME OF CEMETERY or CREMATORY

Balt. Nat'l Cem.

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1968

25B. NAME OF REGISTRAR

Robert E. Jaffee

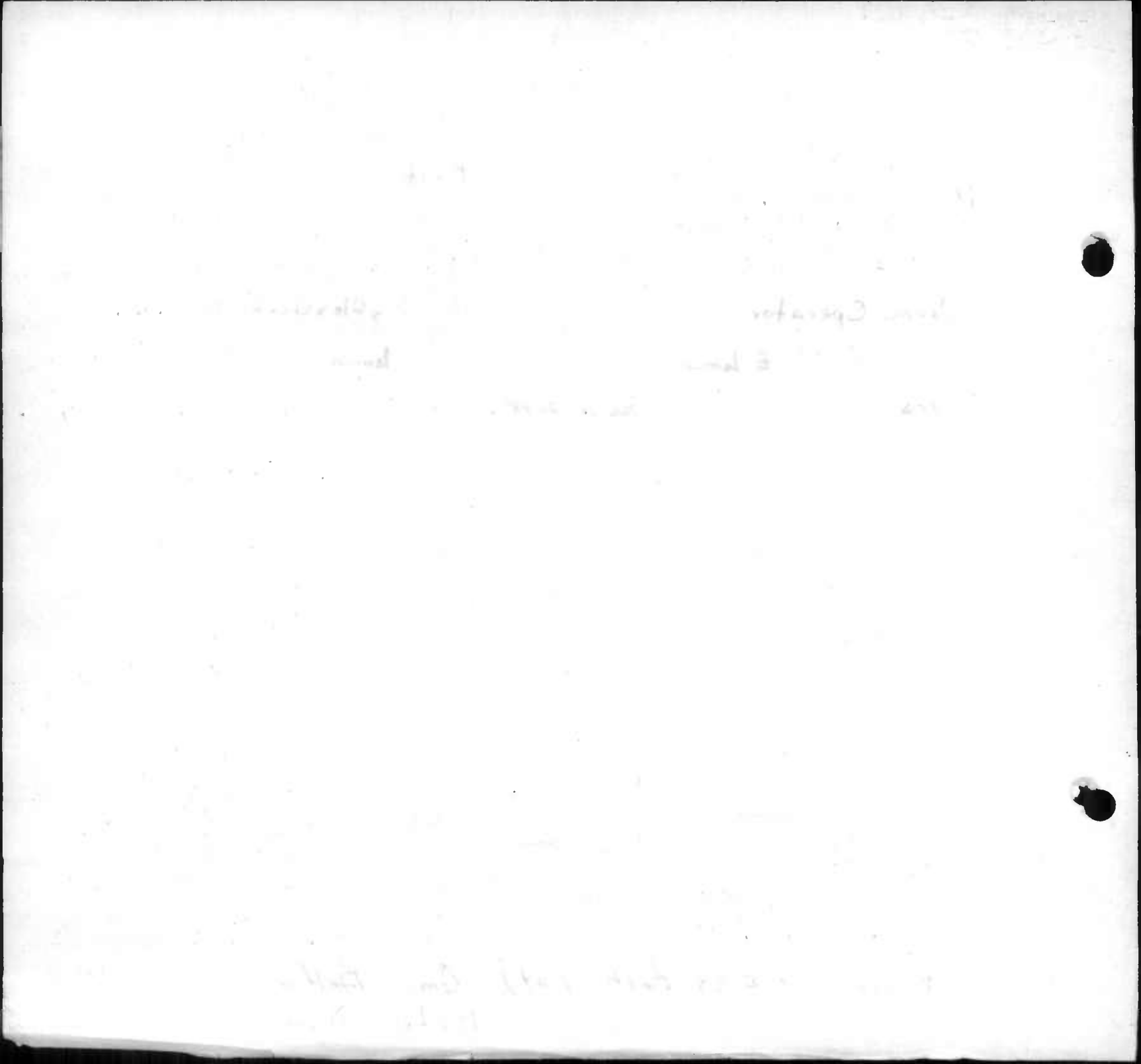
25C. FUNERAL DIRECTOR

Morton &amp; Dyett F.H. 1701 Laurels

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
B-650  
M-350

68- 3631

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3631

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EVELINE S. (BROWN) MADDEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>March 31, 1968</b> Hour <b>8:30 A.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1340 N. Mount Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>March 31, 1968</b> Hour <b>2:45 P.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-02</b>		6. SEX <b>female</b> 7. RACE <b>negro</b> B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>3-28-1928</b>		10. AGE (in years lost birthday) <b>40</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Mt. Olive, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME <b>FLODIE SAMPSON</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>217-24-8826</b>	
18. INFORMANT <b>Mr. Wilbert Sampson</b>		ADDRESS <b>3902 Bereva Rd.</b>	
19. CAUSE OF DEATH <b>571.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Fatty Alteration of Liver</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>5-87.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> <b>Partial Autopsy</b> <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

WALLACE FOR

WALLACE FOR

WALLACE FOR

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-3632				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3632	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Minnie PALMER</i>				2. DATE AND HOUR OF DEATH <i>4/1/68</i> <i>6:35 A</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>16-D8</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>George Washington Nursing Home</i> <i>607 Pennsylvania Ave.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 19, 1886</i> <i>81</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia, Richmond</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Rubin Crawford</i>				14. MOTHER'S MAIDEN NAME <i>Sollie Crawford</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>CHART</i>		ADDRESS <i>Hospital</i>	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>				CAUSE OF DEATH <i>Acute myocardial infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Art. Scientific Heart Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Card-vasc Dis.</i> (C) <i>Unknown</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 hrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1-14-67</i> 19 <i>67</i> to <i>4/1/</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/1/</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>EE Holt M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/1/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>EE HOLT M.D.</i>				23D. ADDRESS <i>3715 Liberty Height ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-5-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balt.</i> <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 3 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H.</i>		ADDRESS <i>1701 Lakewood</i>	



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68-3633

BALTIMORE CITY HEALTH DEPARTMENT

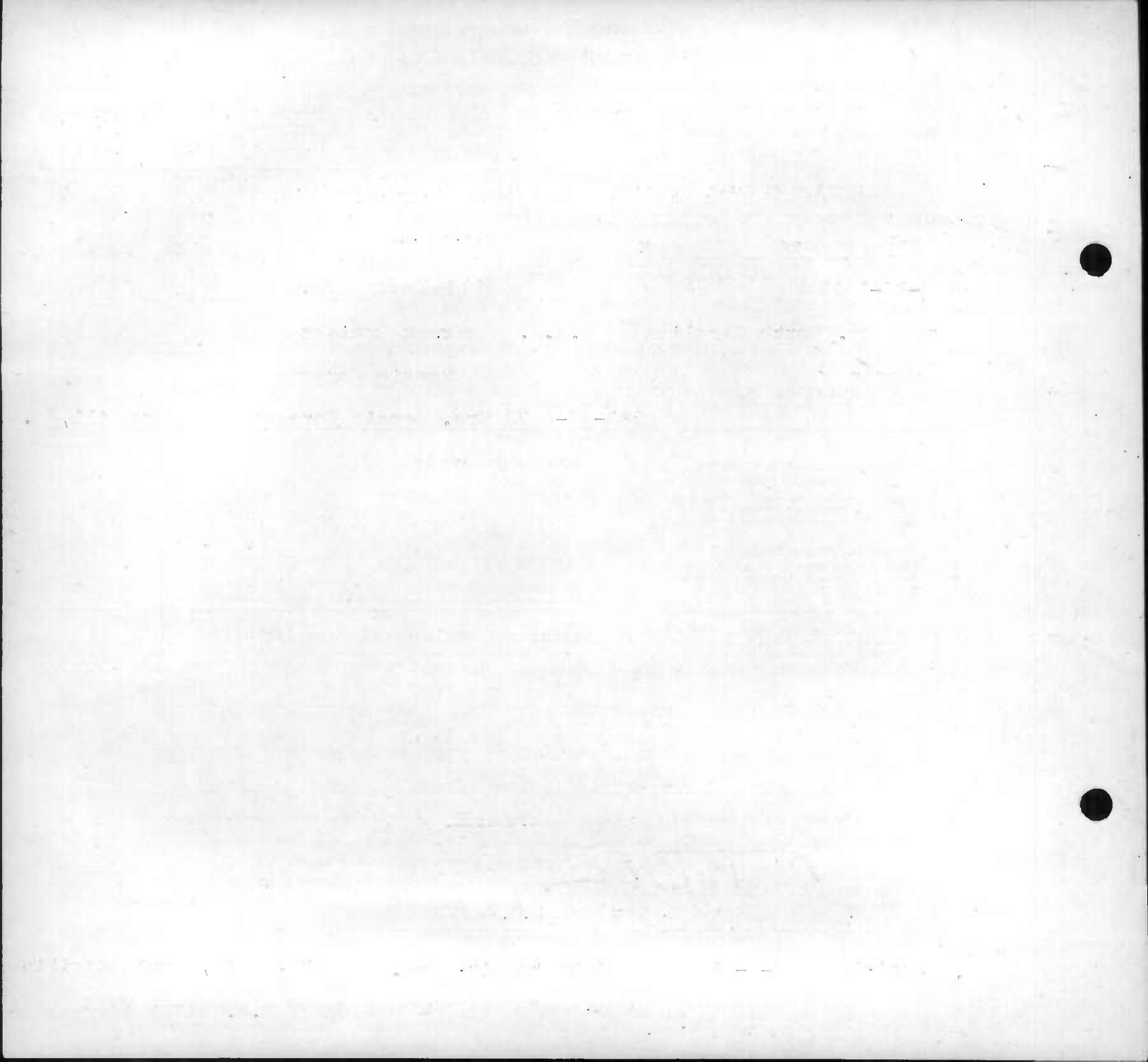
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3633

BIRTH NO.

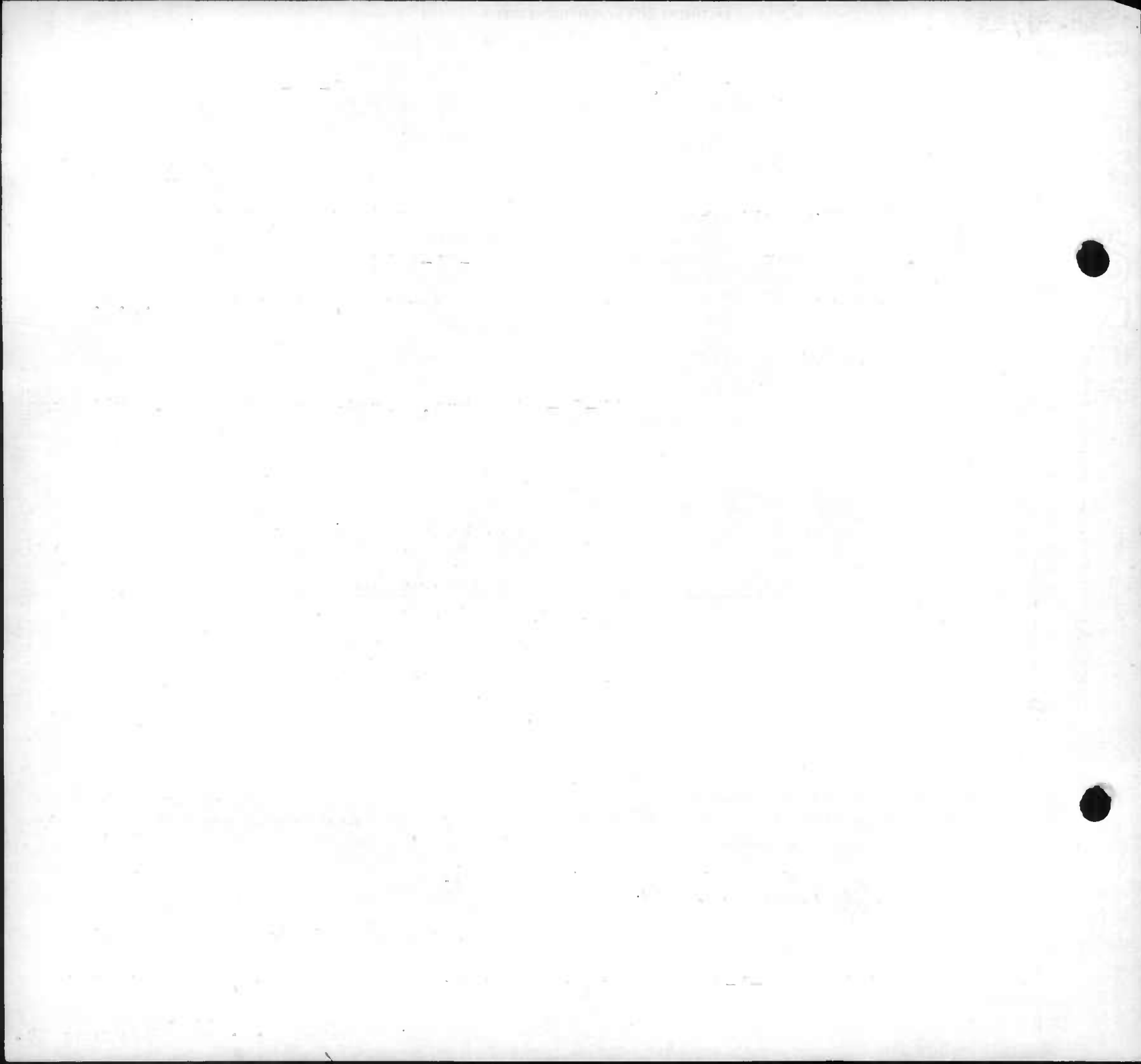
1. NAME OF DECEASED (Type or Print) <b>ERNEST SPEIGHT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>March 29, 1968</b> 9:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>March 29, 1968</b> 9:30 P. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6-16-1932</b>		10. AGE (In years last birthday) <b>35</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Green Co. North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>243-40-6072</b>	
15. MOTHER'S MAIDEN NAME <b>Bessie Foreman</b>		18. INFORMANT <b>Mrs. Bessie Foreman</b>	
19. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic Cardiovascular Disease</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>3-30-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Saints to Lite Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Waston burg, North Carilina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3634		BALTIMORE CITY HEALTH DEPARTMENT		68-3634	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JENNIE B. BASKERVILLE		3-29-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE	
		720 N. Arlington Avenue		MARYLAND	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		720 N. Arlington Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F.	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8-21-1875	92	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Baskerville, Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
CHARLES BENNETT		SUSIE STREET			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		217-54-4924		Mrs. Carrie Bryant 720 N. Arlington	
18. 401X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		Pneumonia			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Capillary Bronchitis			
		(C) Hypertension			
444X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
		Partial Hemiplegia right side			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/12/68 19 to 3/24/68 19 that (I) (we) last saw the deceased alive on 3/24/68 19 and that in (my) (our) opinion death occurred on the date 3/29/68 - 4 AM and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				3/29/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				524 N. Gay St. City (231)	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-1-68		Woodlawn Cemetery	
				Richmond, Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 3 1968		Robert E. Taylor		MORTON & DYETT F.H. 1701 Laurens St.	



F-100

BALTIMORE CITY HEALTH DEPARTMENT

68- 3635

## CERTIFICATE OF DEATH

REG. NO.

68- 3635

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary Louise Febo

2. DATE AND HOUR OF DEATH

April - 1, 1968, 7:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

5725 Newholme Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5725 Newholme Ave

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Aug 15, 1893

9. AGE (In years  
lost birthday)

74

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Antonio Viola

14. MOTHER'S MAIDEN NAME

UPR

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mottavio Leo 5725 Newholme

18. 7/12/9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

Arteriosclerotic Heart Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary insufficiency

(B) DUE TO, OR AS A CONSEQUENCE OF:

Ch. Cong. Heart Failure

(C) DUE TO, OR AS A CONSEQUENCE OF:

Gen. Arteriosclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from July 68 to April 1 1968,  
that (I) (we) lost saw the deceased alive on April 1 July 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. W. Mintzer

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

April 2/1968

23C. PHYSICIAN'S  
NAME (Type)

Dr. Mintzer

23D. ADDRESS

3009 EVERGREEN AVE.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

April 4, 1968

24C. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 3 1968

Robert E. Finkbeiner

Joseph N. Zannini 263 S Conkling

FUNERAL DIRECTOR: IMPORTANT

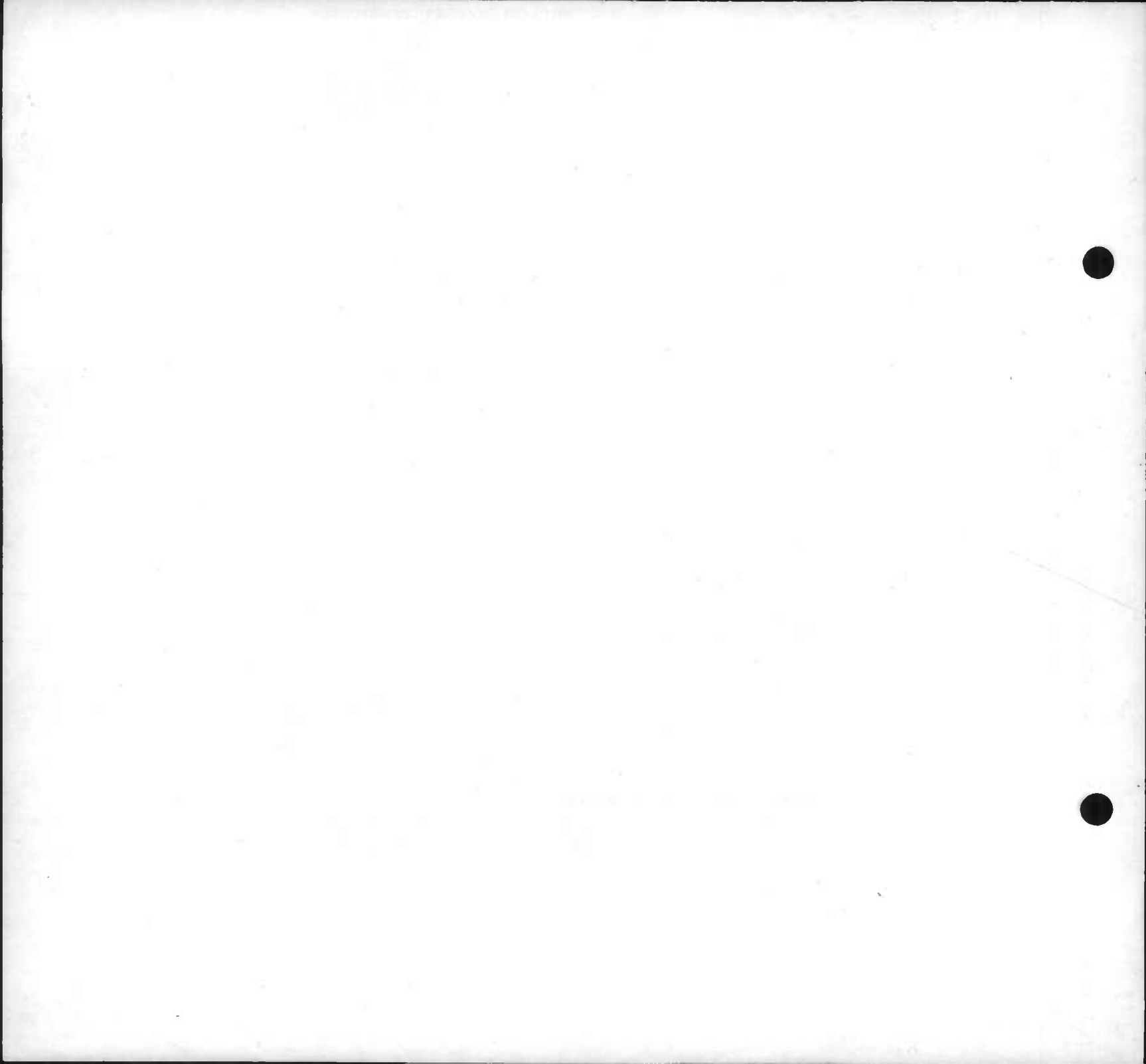
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>68-3636</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>H-252</b></span> <span><b>68-3636</b></span> </div>							
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		<b>LAURA ANDERSON Hawkins</b>		<b>29 March 1968</b>		<b>5 35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>				A. STATE <b>MD</b>			
				B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>648 Noose St</b>				F. INSIDE CITY LIMITS?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-15-08</b>		9. AGE (In years last birthday) <b>59</b>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Finney</b>				14. MOTHER'S MAIDEN NAME <b>Ella Williams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Burdella Cook 1511 Redbank Ave</b>			
				ADDRESS			
18. <b>0389 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
<b>0534 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>28 March 1968</b> to <b>29 March 1968</b> , that (I) (we) last saw the deceased alive on <b>29 March 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>PRONOUNCED BY DR MARCIA SCHMIDT</b>							
23A. SIGNATURE <b>R. P. Wenzel M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>29 March 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. P. WENZEL M.D.</b>				23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burns</b>		<b>4/2/68</b>		<b>Int Auburn</b>		<b>Baltimore MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3637	
M-635 68-3637				CERTIFICATE OF DEATH	
BIRTH NO.				2	
1. NAME OF DECEASED (Type or Print) <b>ZONA MAE MARTIN</b>		2. DATE AND HOUR OF DEATH <b>3/30/68 7<sup>00</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL 38</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>22-01</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>129 W. LEE ST</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/20/31</b>	9. AGE (In years last birthday) <b>36</b>	10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>ZOLLIE FORD</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE JENNINGS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213 28 8225</b>		17. INFORMANT <b>FATHER</b> ADDRESS <b>SAME</b>	
18. <b>231X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EDEMA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MYOCARDIAL INFARCTION</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>HYPOLYCEMIC EPISODES</b> (C) <b>INDETERMINANT</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
19. <b>270X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>MALNUTRITION 2° TO MALABSORPTION 1 YR.</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/29 1968</b> to <b>3/30 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/30 1968</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>GARY PLOTNICK</b>				23B. DATE SIGNED <b>4/1/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>GARY PLOTNICK</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>mt Calvary</b>	
24D. LOCATION (City, town, or county) <b>Brooklyn md</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24F. FUNERAL DIRECTOR <b>Charles A Rice</b> ADDRESS <b>661 W. Barre St</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			

SCOTTIE FORD

913 28 8382

FATHER

2442

PULMONARY EDEMA

MYOCARDIAL INFARCTION  
HYPOTENSIVE EPISODE

MANIFESTATION 20 TO 40 MINUTES

YES

YES

GARY PATRICK



3/2

3/5

3/2

3/30

3/2

3/2

3/2

142 W. LOC ST

3/20/31

142

LOUISE JENNINGS

WOMAN'S HOSPITAL

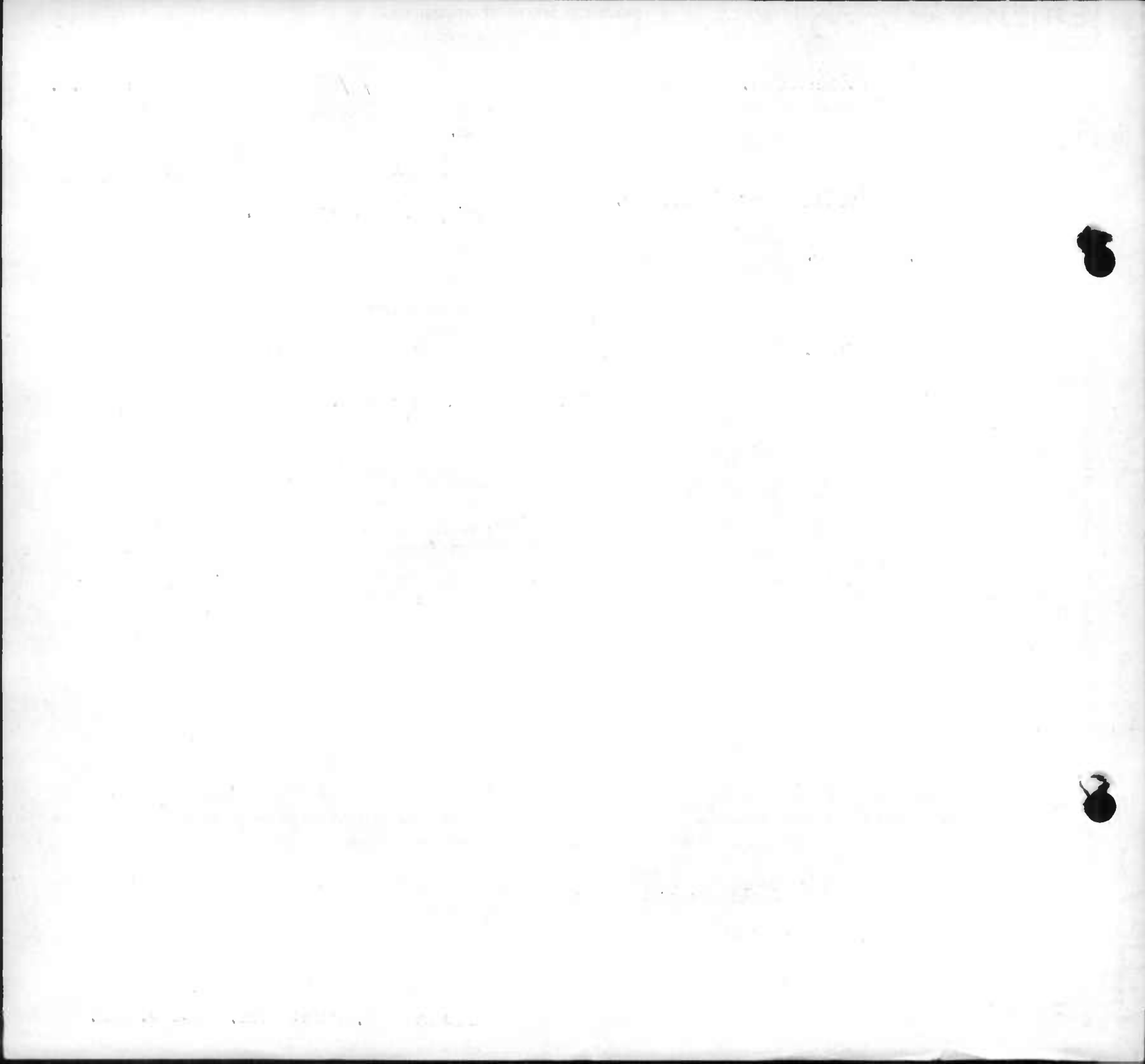
BALTIMORE

MARYLAND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3638</u>
5-530		68-3638		68-3638
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <u>Richard H. Smith</u>		2. DATE AND HOUR OF DEATH <u>4/1/68</u> <u>5:35 P.M.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>6017 Winthrop Ave.</u>		
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/1912</u>	9. AGE (In years lost birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Auto Body</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard E. Smith</u>		
14. MOTHER'S MAIDEN NAME <u>Nellie Nevins</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>212039368</u>		17. INFORMANT <u>Mrs. Marie D. Smith- Same</u>		
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Coronary Thrombosis</u> (B) <u>Coronary - Hypertensive C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Coronary C.V.D. U.M. Hosp.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>6-5-65 to 7-4-65</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>June 5 - 1965</u> to <u>April 1 - 1968</u> , that (I) (we) last saw the deceased alive on <u>Dr. Benedict, March 18 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Bernard J. Cohen, M.D.</u>		23B. DATE SIGNED <u>4/1/68</u>		23C. PHYSICIAN'S NAME (Type) <u>BERNARD J. COHEN</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/4/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">68- 3639</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-300</span> <span style="font-size: 1.5em;">68- 3639</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">CLARA F. SOUTH</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4-2-68</span> <span style="font-size: 1.2em;">7:30 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">34 Bon Secours Hospital</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">5502 Summerfield Ave. 21206</span>		
5. SEX <span style="font-size: 1.2em;">FE</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2-21-12</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Germany</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">LUDWIG FOLZ</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">STERN</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			16. SOCIAL SECURITY NO.		
			17. INFORMANT <span style="font-size: 1.2em;">Mr Edward A South</span> ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. <span style="font-size: 1.2em;">1519 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Carcinoma of stomach</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">with metastases to liver + para-aortic lymph nodes</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">151X II</span> <span style="font-size: 1.2em;">Arteriosclerotic heart disease</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 months</span> <span style="font-size: 1.2em;">years</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">3-23-68</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Possible Cholecystitis</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-16-</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">4-2-</span> 19 <span style="font-size: 1.2em;">68</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-1-</span> 19 <span style="font-size: 1.2em;">68</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J.G. Amayo</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">4-2-68</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J.G. AMAYO</span>			23D. ADDRESS <span style="font-size: 1.2em;">Bon Secours Hosp.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/5/68</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Gardens of Faith</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 3 1968</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Faldut</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Leonard J Ruck Inc, Baltimore, Maryland</span>			



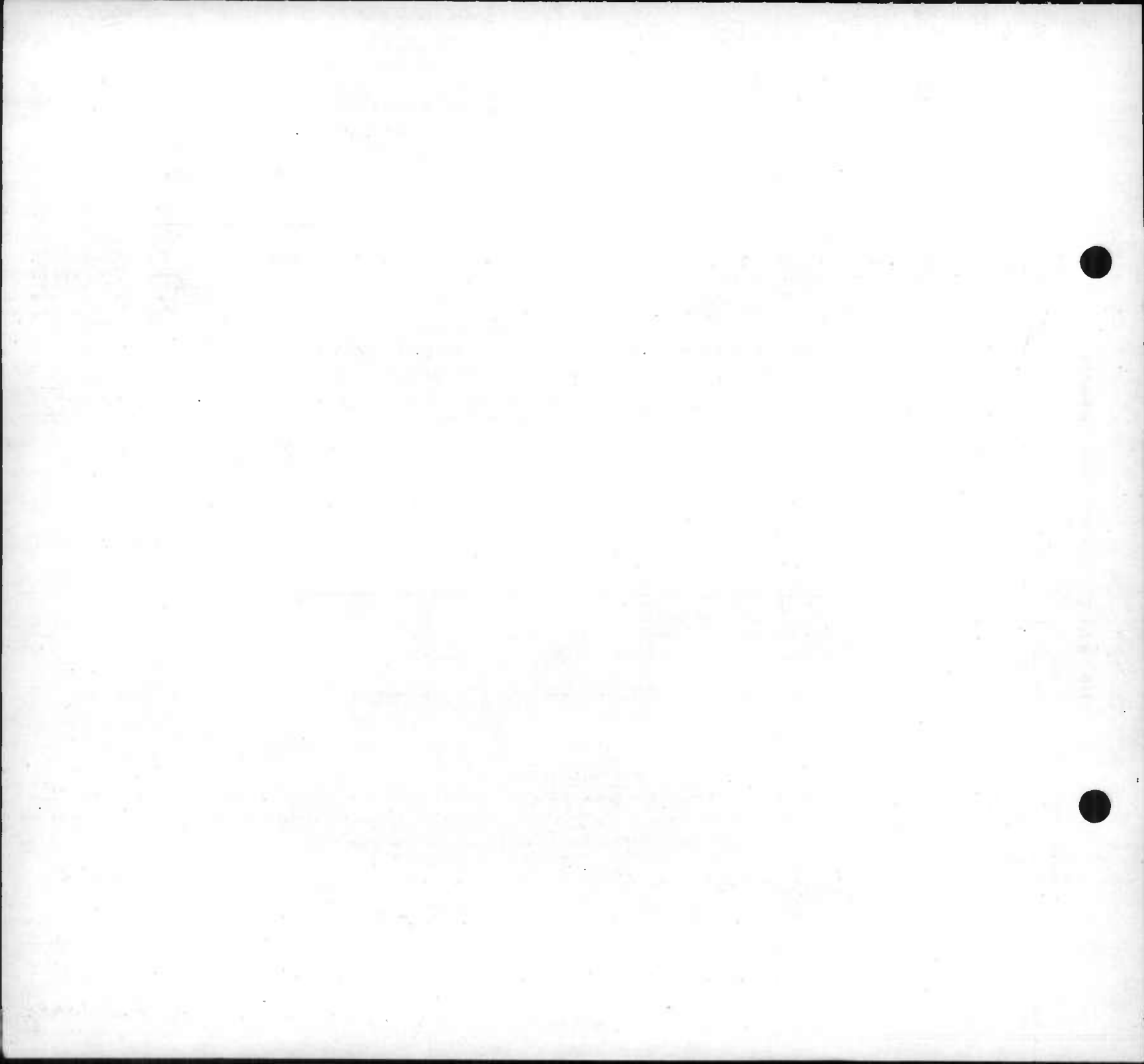
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3640 CERTIFICATE OF DEATH

REG. NO. 68- 3640

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD LIMERICK</b>		2. DATE AND HOUR OF DEATH <b>4/2/68</b> <b>9<sup>15</sup>-A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOUSE OF THE PINES NURSING HOME</b> <b>2525 W BELVEDERE AVE</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>2325 MILLIMAN STREET 21205</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 31 1903</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORK LIFT OPT.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CONTINENTAL CAN CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>EDWARD LIMERICK</b>			14. MOTHER'S MAIDEN NAME <b>ELSIE ARMSTRONG</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-07-6104</b>		17. INFORMANT ADDRESS <b>ELEANOR MILLER 2325 MILLIMAN ST</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Lung.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>163X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Mar 1967</b> to <b>April 2 1968</b> , that (I) (we) last saw the deceased alive on <b>April 1 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum, MD</b> DEGREE				23B. DATE SIGNED <b>4/2/68</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>1115 N. CALVERT ST.</b> DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>APR 5 68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>EASTERN AVE BLVD MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>THE NIPPEL BROS INC 1800 E LOMBARD ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
B-400 68-3641		REGISTERED NO. 68-3641	
BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>JAMES BAILY</b>		2. DATE AND HOUR OF DEATH <b>April 12 1968 12:25 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>12-01</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>100 W. University Pkwy. Balto. Md 21210</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>	
D. STREET ADDRESS (If rural, give location) <b>100 W. University Pkwy</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-24-1889</b> 9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drug "</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S. It.</b>		13. FATHER'S NAME <b>G. Frank Baily</b>	
14. MOTHER'S MAIDEN NAME <b>Nancy Irwin Carey</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES, World War I</b>	
16. SOCIAL SECURITY NO. <b>219-20-5295A</b>		17. INFORMANT <b>Mrs. James Baily - 100 W. University Pkwy Balto. Md. 21210</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>204017-0119</b>		CAUSE OF DEATH <b>Acute Lymphatic LEUKEMIA</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>204.3 II</b>		TUBERCULOSIS, Chronic	
19A. DATE OF OPERATION <b>0 None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 19 1964</b> to <b>April 12 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>March 31 1968</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.			
23A. SIGNATURE <b>A.S. Chalfant</b>		23B. DATE SIGNED <b>April 12 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>A.S. CHALFANT</b>		23D. ADDRESS <b>6210 York Rd, Baltimore Md. 21212.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Green Mount</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 3 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers - 8728 Liberty Road.</b>		25D. ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="font-size: 1.2em;">68- 3642</span>	
BIRTH NO. <span style="font-size: 1.5em;">H-524</span> <span style="font-size: 1.5em;">68- 3642</span>							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HENSEL, WILLIAM</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3/31/68 11:15 P.</span> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">42 SINAI HOSPITAL</span>				C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">3301 PARK CIRCLE</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov. 14, 1886</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Self-employed</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Retail Fruit &amp; Produce</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="font-size: 1.2em;">William Hensel</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Ullrick</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-32-9806</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Margaret Hensel, 3301 Park Circle</span>			
18. <span style="font-size: 1.2em;">785-X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <span style="font-size: 1.5em;">BRONCHOPNEUMONIA</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">CHRONIC OBSTRUCTIVE LUNG DISEASE</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1-2 days</span>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">491X II</span>							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>this hospital</del> attended the deceased from <span style="font-size: 1.2em;">3-31-68</span> 19 to <span style="font-size: 1.2em;">3-31</span> 19 <span style="font-size: 1.2em;">68</span> , that (I) <del>we</del> last saw the deceased alive on <span style="font-size: 1.2em;">3-31</span> 19 <span style="font-size: 1.2em;">68</span> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Alan F. Wolf, M.D.</span>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">3/31/68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ALAN F. WOLF, M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/4/1968</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 3 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">GIVEN SUMNER 4611 Park Heights Ave.</span>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3643</u>
5-322 68-3643		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>CHARLES W. STOKES</u>		2. DATE AND HOUR OF DEATH <u>4/2/68</u> <u>5:05 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CERTIFICATE AMENDED</u> FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>4-16-68</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>BARCLAY Street 2109</u>		
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 '42</u> <u>23</u> yrs	9. AGE (In years lost birthday) <u>23</u> yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Robert C. Stokes</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Lee, same as deceased</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown YES</u>		16. SOCIAL SECURITY NO. <u>216-366719</u>		17. INFORMANT <u>Maudie (ma) Stokes</u>
18. <u>303.1</u> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Acute Pancreatitis</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 hours</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>322.2 II</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>4/1/68</u> to <u>4/2/68</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>4/2/68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <u>Dermot Campbell M.D.</u>				23B. DATE SIGNED <u>4/2/68</u>
23C. PHYSICIAN'S NAME (Type) <u>DERMOT CAMPBELL MD</u>		23D. ADDRESS <u>THE Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-5-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>JOSEPH KNIGHT 1639 N. BROADWAY</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

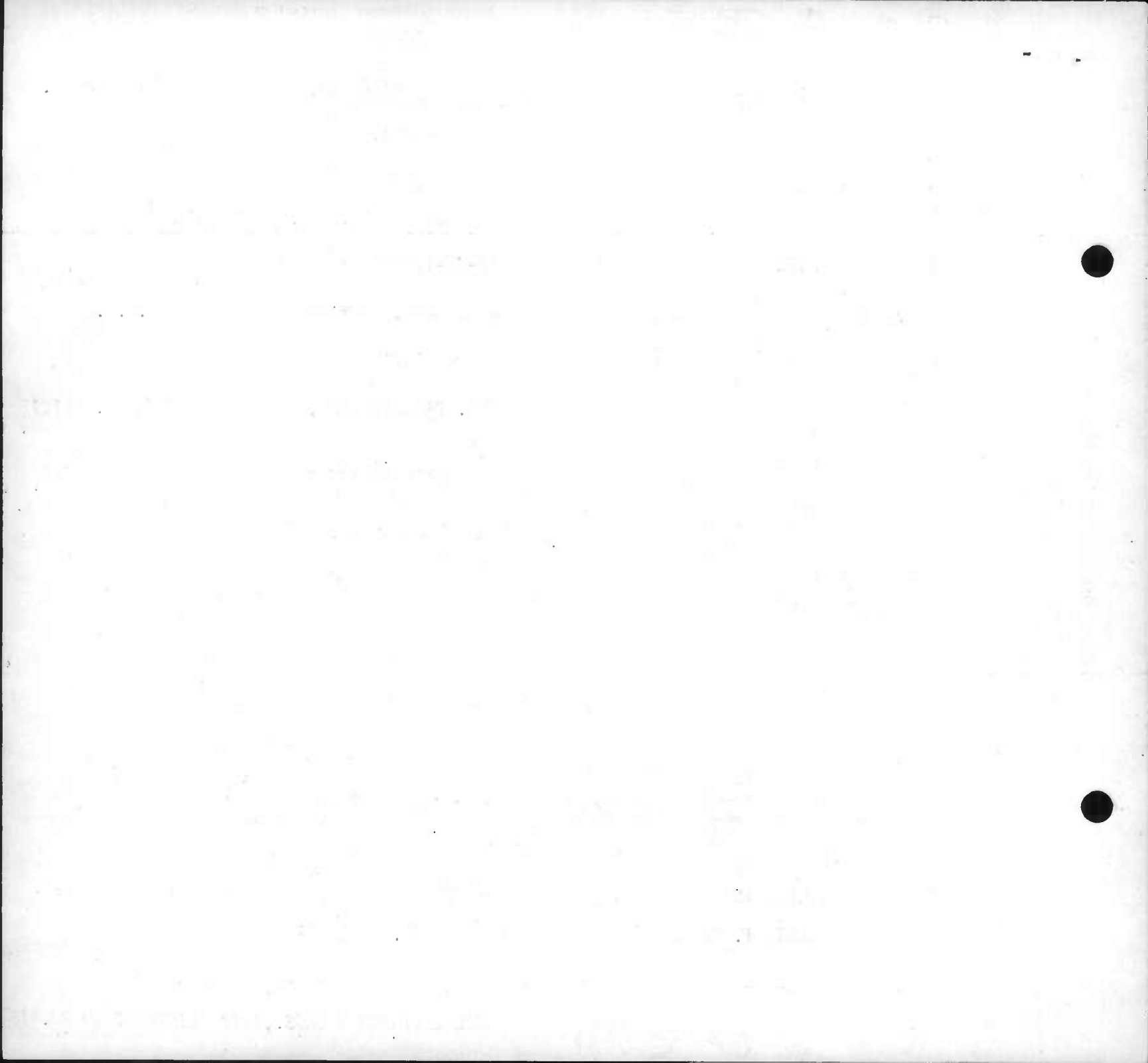
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-3644	
A-250 68-3644											
BIRTH NO. <del>XXXXXX</del> , <del>XXXXXX</del>											
1. NAME OF DECEASED (Type or Print) <del>XXXXXX</del> <del>XXXXXX</del> DAVID AIKEN						2. DATE AND HOUR OF DEATH 3/28/68 10 41 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <del>XXXXXX</del> MARYLAND B. COUNTY <del>XXXXXX</del> Md.					
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL						C. CITY OR TOWN Baltimore City					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 5431 Gist Ave.						27-18					
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/1899		9. AGE (In years last birthday) 68		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT						10B. KIND OF BUSINESS OR INDUSTRY RETAIL					
11. BIRTHPLACE (State or foreign country) VANESICK, LITHUANIA						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME ISRAEL AIKEN						14. MOTHER'S MAIDEN NAME FANNIE ROSENBERG					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. 216-03-5184					
17. INFORMANT MRS. EVA AIKEN, 5431 GIST AVE., BALTO. 21215						ADDRESS					
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY ARTERIOSCLEROSIS						10 yrs					
(C) Ductile Myelitis						15 yrs					
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 3/28/68 19 68 to 3/28/68 19 68, that (I) (we) last saw the deceased alive on 3/28/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Irvin Sauber, MD								23B. DATE SIGNED 3/28/68			
23C. PHYSICIAN'S NAME (Type) IRVIN SAUBER, MD								23D. ADDRESS 6905 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 3-31-68				24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION			
24D. LOCATION ROSEDALE, MARYLAND				24E. (City, town, or county)				24F. (State)			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR APR 4 1968 R. B. E. Fink				25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
25D. ADDRESS #21215											



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		68- 3645		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3645	
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HERMAN COHN				MARCH 28, 1968		5:55 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
SINAI HOSPITAL				MARYLAND			
42				C. CITY OR TOWN			
				BALTIMORE			
E. STREET AND NUMBER				INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3409 DEVONSHIRE DRIVE #21215							
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Hours	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-24-1899	68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BROKER		REAL ESTATE		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ISADORE COHN				HENRIETTA DREGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO						ADDRESS	
				MRS. PAULINE COHN, 3409 DEVONSHIRE DR. #21215			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Myocardial infarct Sudden			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Lifespan			
(C).....							
420.1 II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 1967 to Mar 28 1968, that (I) (we) last saw the deceased alive on Dec 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Louis P. Hamburger				Mar 29, 1968			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LOUIS P. HAMBURGER				1001 ST. PAUL STREET			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		3-29-68		HEBREW FRIENDSHIP		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 4 1968		Robert E. Finkbeiner		SOL LEVINSON & BROS.		6010 REISTERSTOWN RD. #15	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decedent was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3646</u>
F-635 68-3646				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>IDA FREEDENBERG</b>		
2. DATE AND HOUR OF DEATH <b>MARCH 30, 1968</b>		1. A.M. <input checked="" type="checkbox"/> P.M. <input type="checkbox"/>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>PALL MALL NURSING HOME</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>PALL MALL NURSING HOME</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>8-10-1893</b>		9. AGE (In years last birthday) <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>
11. BIRTHPLACE (State or foreign country) <b>CHICAGO, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID LOUIS DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>ESTHER ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MISS RITA FREEDENBERG, 7922 DUNHILL VILLAGE CIRCLE, APT. 204, Balto.</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.9 I</b> <b>Coronary Occlusion</b> <b>Immed</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>		(B) <b>Coronary Arteriosclerosis</b> (C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Mar 1 1968</b> to <b>Mar 30 1968</b> , that (I) (we) last saw the deceased alive on <b>Mar 28 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Irvin Sauber</b>		23B. DATE SIGNED <b>3-30-68</b>		23C. PHYSICIAN'S NAME (Type) <b>IRVIN SAUBER</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>3-31-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>ANSHE EMUNAH; AITZ CHAIM</b>
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 1 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215</b>		

10-1-77

10-1-77

10-1-77

10-1-77

10-1-77

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ESTHER

GOLDBERG

2. DATE  
OF  
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

March 28, 1968

10:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Apt. 802 100 West Coldspring Lane

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March 28, 1968

10:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Female

7. RACE

White

B. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

APRIL 19, 1932

10. AGE (In years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Apt. 802 100 West Coldspring Lane

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE GOLDBERG

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

NONE

14B. KIND OF BUSINESS OR INDUSTRY

NONE

15. MOTHER'S MAIDEN NAME

SONIA

?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

18. INFORMANT

MR. GEORGE GOLDBERG, SEVERNA PARK, MARYLAND

19.

E150.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Overdose of Barbiturate

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Apt. 802 100 W. Coldspring Lane

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

3

28

68

?

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Overdose of Barbiturate

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Korhblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-29-68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

3-31-68

24C. NAME of CEMETERY or CREMATORY

HEBREW FRIENDSHIP

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

APR 4 1968

25B. NAME OF REGISTRAR

Robert E. Sankel, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC.

ADDRESS

6010 REISTERSTOWN ROAD, BALTO. 21215

APRIL 19, 1952

DETROIT, MICHIGAN

HOME

HOME

HOME

NO

NO 12, 1951

DETROIT, MICHIGAN

DETROIT, MICHIGAN

DETROIT, MICHIGAN

DETROIT, MICHIGAN

DETROIT, MICHIGAN

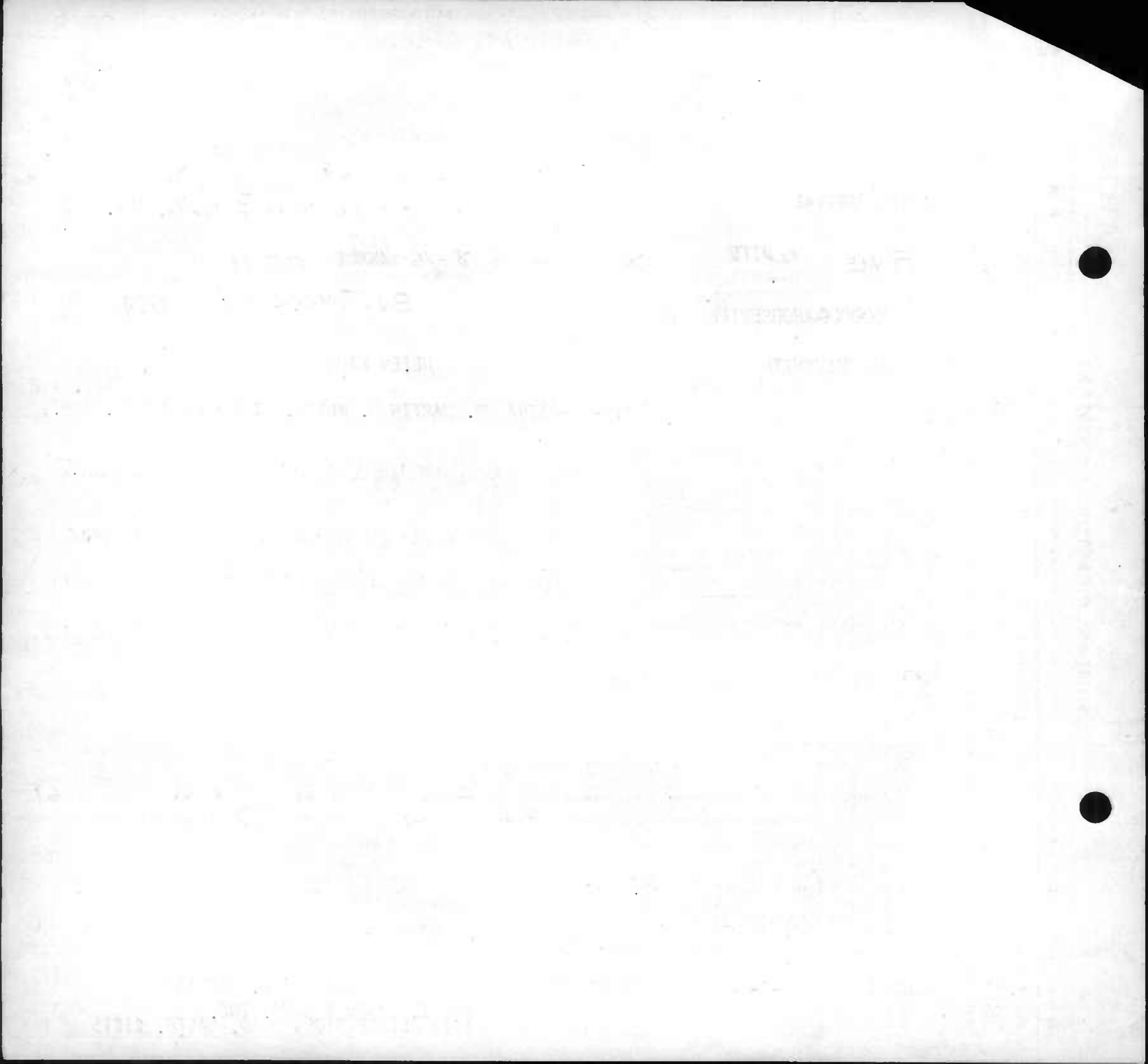
DETROIT, MICHIGAN

DETROIT, MICHIGAN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

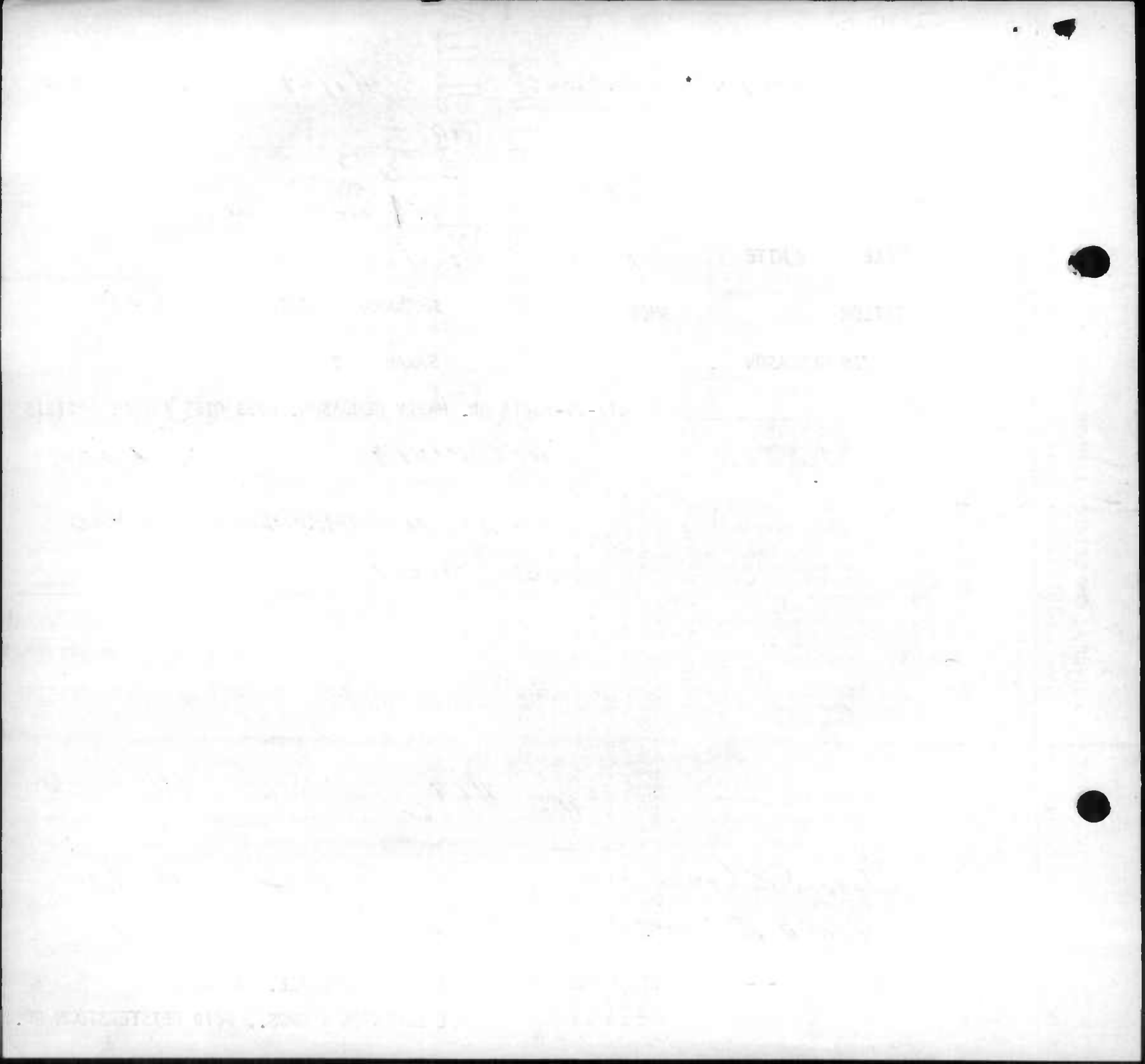
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3648</u>
<p><b>BIRTH NO.</b></p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>ETA J. White</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>3-31-68</u> <u>11<sup>25</sup></u> <u>PM</u></p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>6109 PARK HEIGHTS AVE, APT. 1 B</u></p>		
<p><b>5. SEX</b> <u>FEMALE</u></p>	<p><b>6. RACE</b> <u>WHITE</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>1889</u> <u>8-16-</u> <u>78</u></p> <p><b>9. AGE</b> (In years lost birthday) <u>78</u></p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>AT HOME</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTIMORE, Md.</u></p>
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u></p>		<p><b>13. FATHER'S NAME</b> <u>MAX GOLDSMITH</u></p>		
<p><b>14. MOTHER'S MAIDEN NAME</b> <u>HELEN KAHN</u></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		
<p><b>16. SOCIAL SECURITY NO.</b> <u>219-30-2579A</u></p>		<p><b>17. INFORMANT</b> <u>MR. MARTIN M. WHITE, 6109 PARK HIGHTS, AVE., APT. 1 B</u></p>		
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Intestinal Obstruction</u></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Recurrence of Carcinoma of Colon</u> (C) <u>Carcinoma of Colon, recurrence</u></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 month</u> <u>1 year</u> <u>31 years</u></p>				
<p><b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>Atherosclerotic heart disease</u></p>				
<p><b>19A. DATE OF OPERATION</b> <u>02-22-68</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>Intestinal Obstruction</u></p>		
<p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>		
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>		
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>2-18</u> <u>1968</u> <b>to</b> <u>3-31</u> <u>1968</u>, <b>that (I) (we) last saw the deceased alive on</b> <u>3-31</u> <u>1968</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>3-31</u> <u>1968</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>				
<p><b>23A. SIGNATURE</b> <u>Ok. Chung</u> <u>MB, BS</u></p>		<p><b>23B. DATE SIGNED</b> <u>3-31-68</u></p>		
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <u>RAPHAEL S. K. CHUNG</u> <u>MB, BS</u></p>		<p><b>23D. ADDRESS</b> <u>Sinai Hospital of Baltimore, Baltimore Md.</u></p>		
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u></p>		<p><b>24B. DATE</b> <u>4-1-68</u></p>		
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>BALTIMORE HEBREW</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u></p>		
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>APR 1 1968</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>Sol Levinson &amp; Bros, Inc.</u></p>		
<p><b>25C. FUNERAL DIRECTOR</b> <u>6010 REISTERSTOWN ROAD, BALTO. 21215</u></p>		<p><b>ADDRESS</b></p>		



FUNERAL DIRECTOR: IMPORTANT

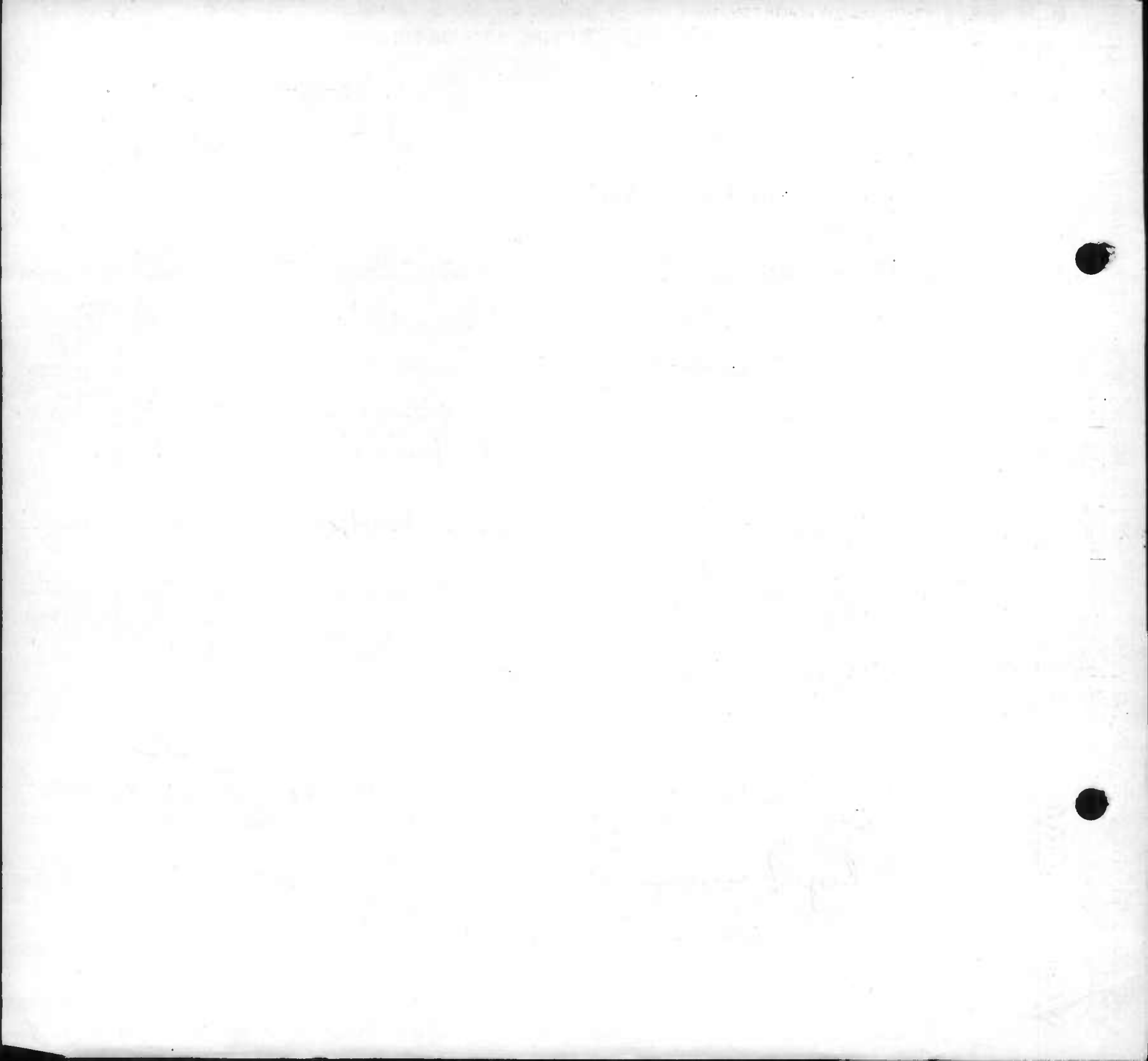
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-532		68-3649		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3649	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BENJAMIN B. GENDASON</b>				2. DATE AND HOUR OF DEATH <b>4/1/68 7:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Sinai Hosp of Balto.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-18</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>5346 GIST Ave.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/83</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MORRIS GENDASON</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-09-3341A</b>		17. INFORMANT <b>MR. HARRY GENDASON, 5356 GIST AVENUE #21215</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRAL ART THROMBOSIS</b> <b>GEN ASCUR</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
19. DATE OF OPERATION <b>4-2-68</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>4/1/68</b> to <b>4/1/68</b> that (I) <u>(we)</u> last saw the deceased alive on <b>4/1/68</b> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <b>Edward R. Cohen, M.D.</b>				23B. DATE SIGNED <b>4/1/68</b>		23C. PHYSICIAN'S NAME (Type) <b>EDWARD R. COHEN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-2-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH HAMEDROSH HAGODOL</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN RD.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3650	
BIRTH NO. <u>2-453</u>		68-3650		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>TRACY PALMATARY</u>			2. DATE AND HOUR OF DEATH <u>3-30-68</u>   <u>12.25 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>QUEEN ANN</u>		
			C. CITY OR TOWN <u>MD.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-68</u>	9. AGE (In years lost birthday) <u>--</u>	If Under 1 Yr. Months Days <u>47</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>HARVEY G. PALMATARY</u>			14. MOTHER'S MAIDEN NAME <u>SHARON WHITE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Harvey Palmatary</u>		ADDRESS <u>Queen Anne</u>
18. <u>74623 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>754.2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congenital heart disease - VSD</u>		CAUSE OF DEATH <u>Heart Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congenital heart disease - VSD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 wks</u>	
19A. DATE OF OPERATION <u>3/28/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Septal Defect</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 28</u> 19 <u>68</u> to <u>March 30</u> 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>March 30</u> 19 <u>68</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Coyle Freeman M.D.</u>				23B. DATE SIGNED <u>3-30-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>COY FREEMAN</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-31-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	
24D. LOCATION <u>Stevensville</u>		24E. (City, town, or county) <u>MD.</u>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Edgar L Lane</u>	
				ADDRESS <u>Church Hill Md</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 3651 CERTIFICATE OF DEATH					REG. NO. 68- 3651				
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Ira V. Phelps Sr.					2. DATE AND HOUR OF DEATH March 31, 1968 8:00 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7304 Betz Ave.				
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1901	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Francis Phelps					14. MOTHER'S MAIDEN NAME Blanche A. Birkey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-03-5390		17. INFORMANT (Wife) Mrs. Mary Phelps, 7304 Betz Ave. Edgemere.			ADDRESS Md. 21219	
18. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary infarction CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HASCUD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 20 years. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					443 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 15, 1959 to March 31, 1968, that (I) (we) last saw the deceased alive on March 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John V. Conway					23B. DATE SIGNED 4/1/68			23C. PHYSICIAN'S NAME (Type) John V. Conway	
23D. ADDRESS M.D. 914 "D" Street, Sparrows Point, Md. 21219					24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
24B. DATE 4/3/68					24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park				
24D. LOCATION Dorsey, Maryland					25A. DATE REC'D BY HEALTH DEPT. APR 4 1968				
25B. NAME OF REGISTRAR Robert E. Farber					25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				

Volume of report

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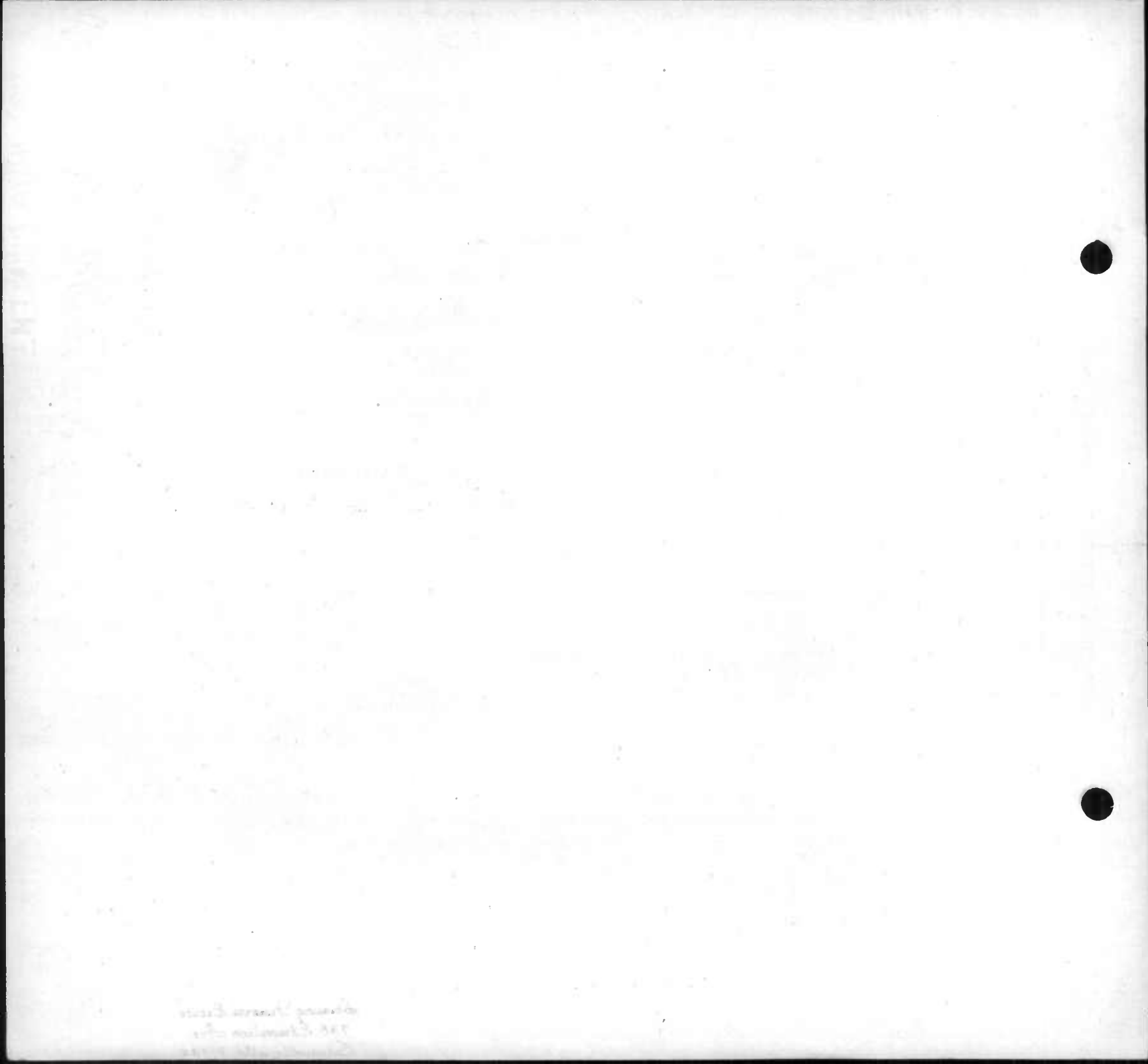
March 21, 1955

John G. Gurney

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

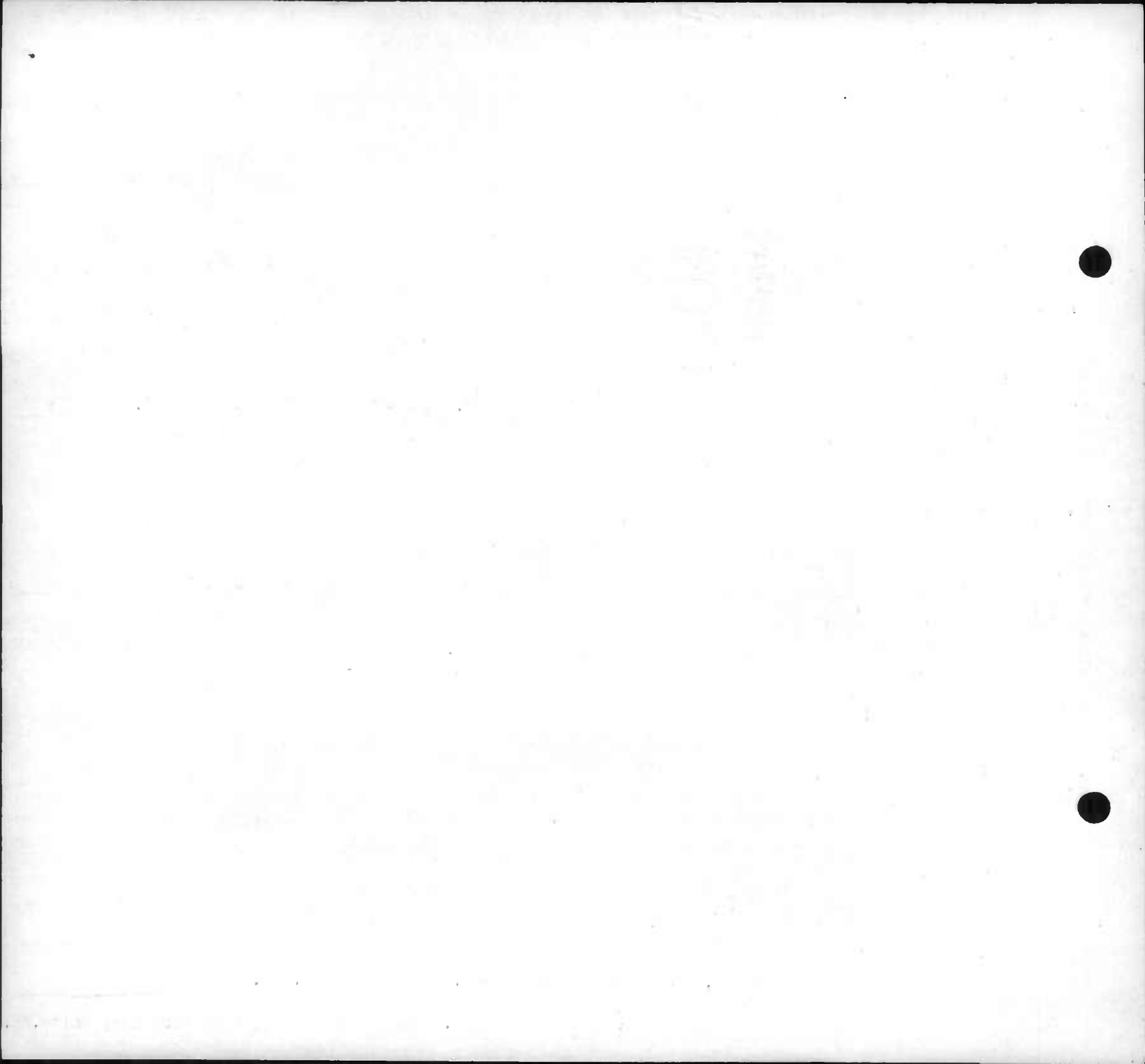
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3652</b>
M-536 68-3652		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED <b>MILDRED A. MUNDORF</b> (Type or Print) <b>Mildred A. Mundorf</b>		2. DATE AND HOUR OF DEATH <b>3-31-68-5AM</b> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON Secours Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1911 Clifden Rd.</b>		
5. SEX <b>Female</b>	6. RACE <b>White.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1910</b>	9. AGE (In years lost birthday) <b>57 y. old</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
13. FATHER'S NAME <b>BENJAMIN Reese</b>		14. MOTHER'S MAIDEN NAME <b>Amelia FREIRICH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>Howard B. Mundorf 1911 Clifden RD.</b>
18. <b>162.1 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <b>Adenocarcinoma of lung with metastases to cerebellum</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>				
163X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <b>3-23-1968</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CEREBELLAR TUMOR</b>	20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 19 1968</b> to <b>MARCH 31 1968</b> , that (I) (we) last saw the deceased alive on <b>MARCH 31 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b> M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-31-1968</b>
23C. PHYSICIAN'S NAME (Type) <b>B. MARTINEZ</b> M.D. DEGREE		23D. ADDRESS <b>Bon Secours Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 3, 1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lakeview mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Carroll County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Stirling Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

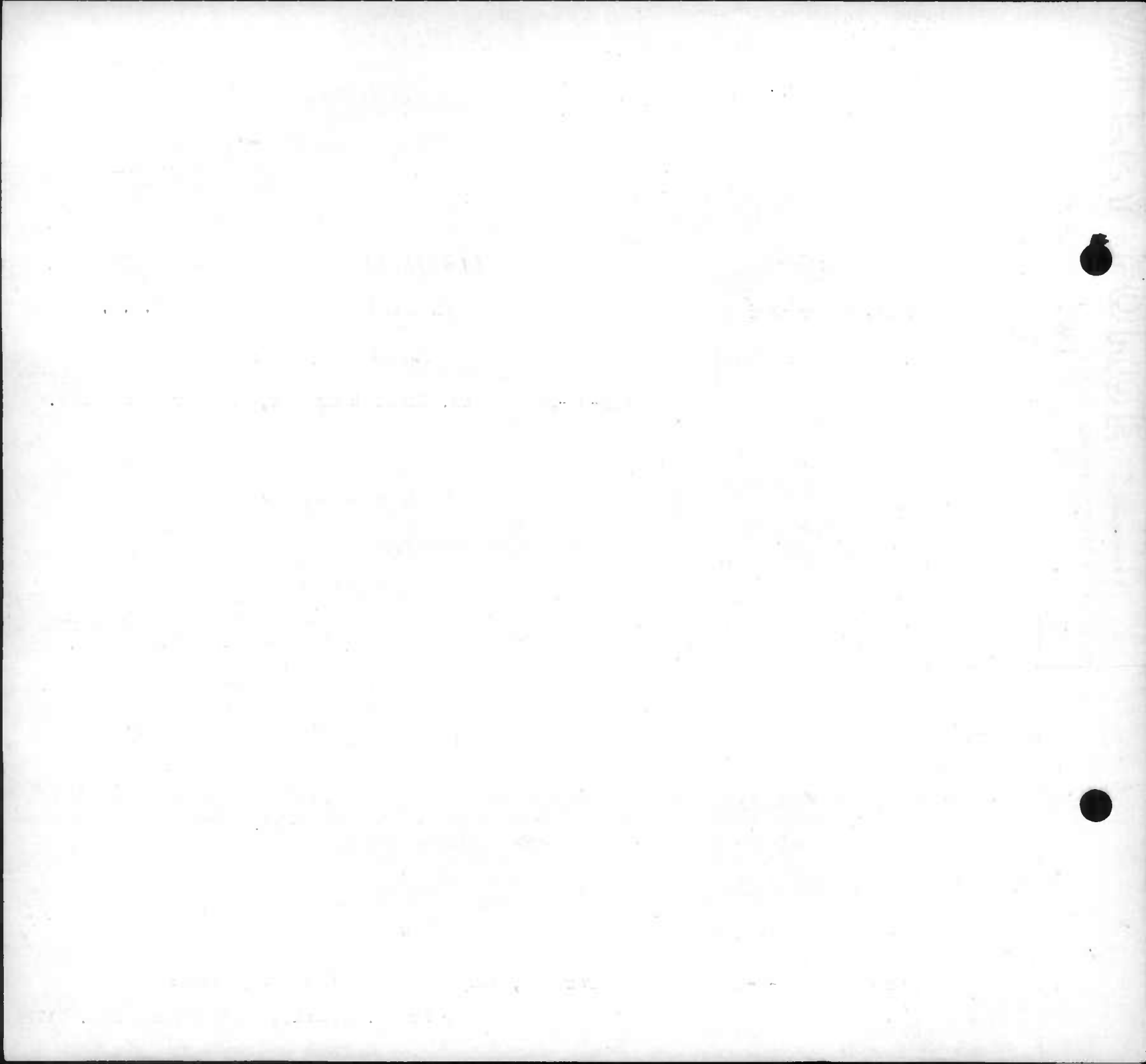
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3653</u>
W-410		68-3653		<b>CERTIFICATE OF DEATH</b>
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>WOLF Conrad</u>		4-2-68 3:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>245 S. Hilton St.</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1883</u>	9. AGE (In years last birthday) <u>84</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sebastian Wolf</u>		
14. MOTHER'S MAIDEN NAME <u>Kate Spoerk</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>215-03-5449</u>		17. INFORMANT ADDRESS <u>Mr. Jacob Wolf 407 Yale Ave, Balto. Md/ 21229</u>		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>UREMIA</u>		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) <u>Renal Failure</u>		
ANTECEDENT CAUSES		(C) <u>Severe Arteriosclerosis + Cardiac Failure</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
19A. DATE OF OPERATION <u>4-5-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		
19C. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> 19 <u>68</u> to <u>4/2</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>René O. Santiago</u>		23B. DATE SIGNED <u>4/2/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>RENE O. SANTIAGO</u>		23D. ADDRESS <u>Bon Secours Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>April 5, 1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>G. Truman Schwab 3512 Frederick Ave, Balto. Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 104923
G-426 68-3654 CERTIFICATE OF DEATH				68-3654
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Martin F. Gallagher</u>		
2. DATE AND HOUR OF DEATH <u>April 2, 1968</u> <u>5</u> <u>a.m.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>2025 W. Fayette Street</u> <u>Baltimore, Md. 21223</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21229</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>355 Martingale Avenue</u>		5. SEX <u>male</u> 6. RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/28/1899</u> 9. AGE (In years last birthday) <u>68</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas F. Gallagher</u>		
14. MOTHER'S MAIDEN NAME <u>Nellie Kane</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>213-09-5890</u>		17. INFORMANT <u>Mrs. Ethel Gallagher, 355 Martingale Ave.</u>		
ADDRESS <u>21229</u>				
18. <u>162.1</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of lung with extension to pericardium.</u>		<u>3 months</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____				
19. <u>163X</u> II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>2 weeks</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3-6-</u> <u>1968</u> to <u>4-2-</u> <u>1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4-2-</u> <u>1968</u> and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Hashemi</u> M.D. DEGREE				23B. DATE SIGNED <u>4/2/68</u>
23C. PHYSICIAN'S NAME (Type) <u>M. J. HASHEMI</u> M.D. DEGREE				23D. ADDRESS <u>Bon Secours Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 3655</span>	
5-455		68- 3655		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM E. SALMON		4/2/68 5 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  THE JOHNS HOPKINS HOSPITAL 33			A. STATE MARYLAND		
			B. COUNTY		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
BALTIMORE 21229			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			APT 11 OAKLEE VILLAGE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-6-00	67	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Balto. City Police		Minnesota	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WILLIAM J. SALMON			EVELYN RINGHAM		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		212-46-8538		Mrs. Margaret A. Salmon, 11 Oaklee Village	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Cardiorespiratory arrest</i>  <i>CO PD</i>  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19A. DATE OF OPERATION			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			NO		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that <del>the</del> (this hospital) attended the deceased from 19 to 4/2 1968, that <del>the</del> (we) last saw the deceased alive on 4/2 1968 and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(We)</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. M. MEAGHER, M.D. DEGREE				4/2/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
H. M. MEAGHER		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-6-1968		Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 4 1968		Howard H. Hubbard		4107 Wilkens Ave. 21229	

Geographical area

CO 9D

Long term, intermediate

No

4/2

x

or

4/2

x

x

x

x

H. M. WEDDER

H. M. WEDDER

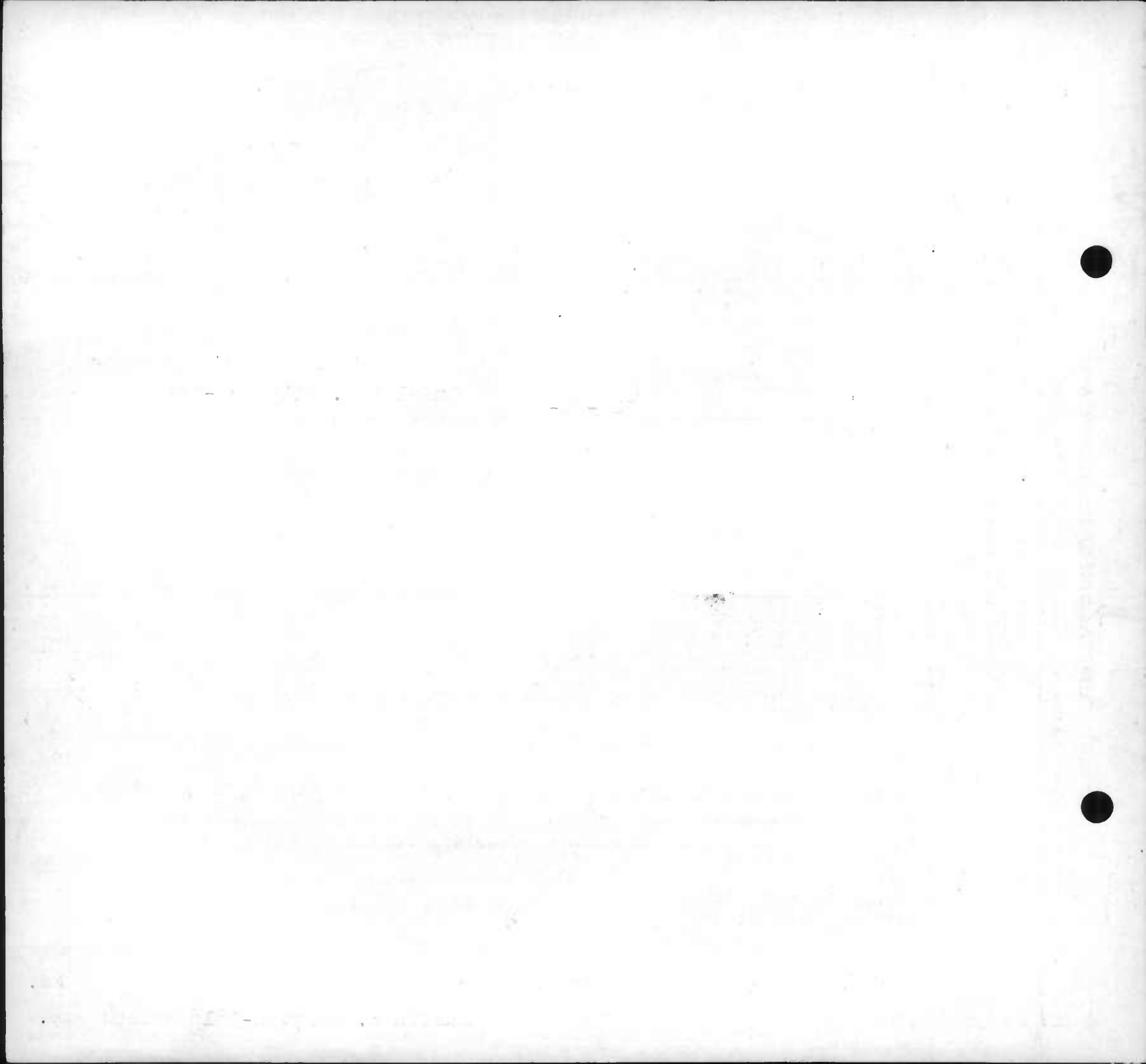
THE JOHN HOPKINS

100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

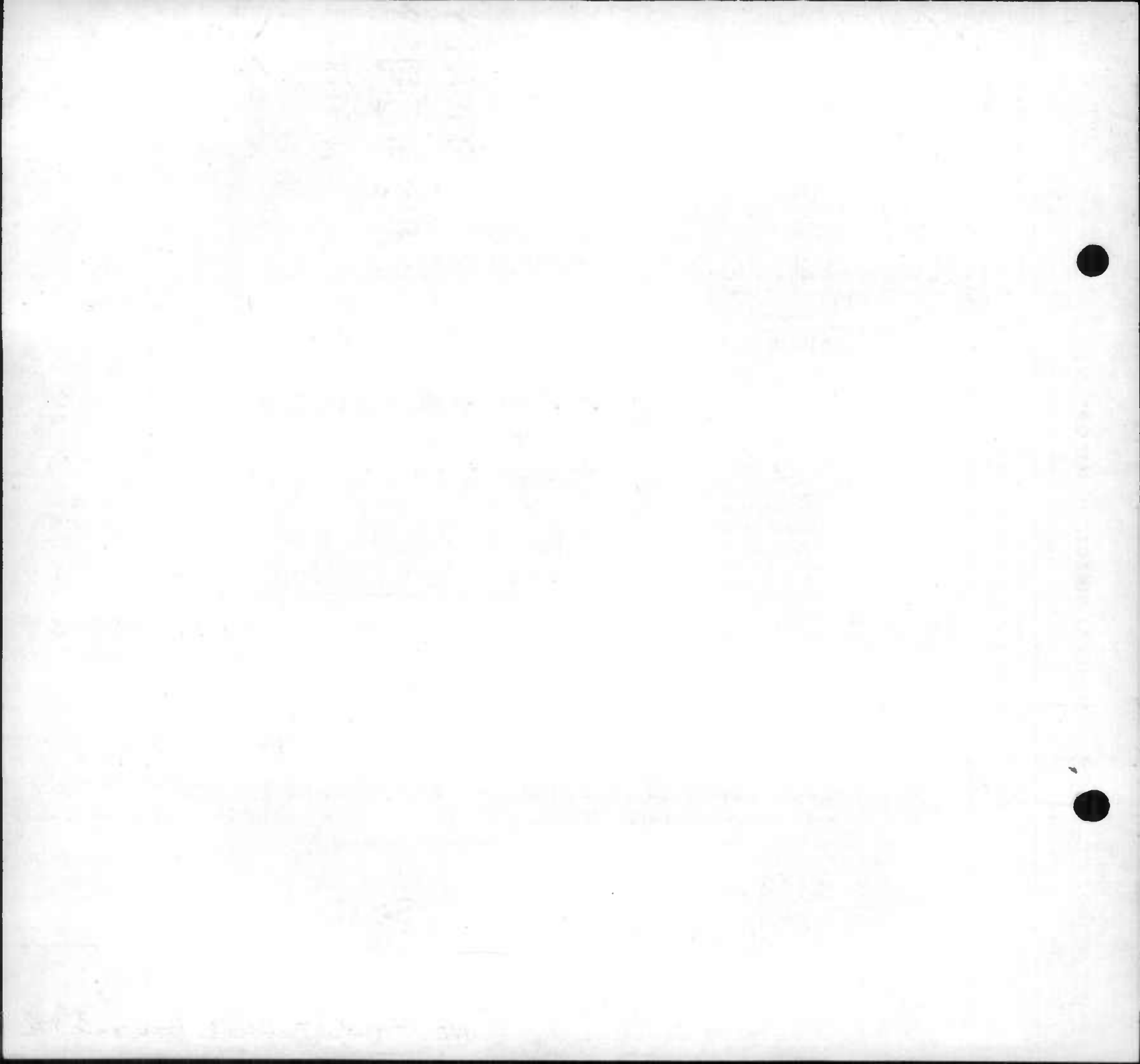
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3656</u>	
B-426		68-3656		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Blizzard, Florence</u>		2. DATE AND HOUR OF DEATH <u>4-1-68</u> <u>9:40 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2 Sinai Hosp. Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3617 Malden Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-10</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Michael Buckheit</u>		14. MOTHER'S MAIDEN NAME <u>Howard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-6868</u>		17. INFORMANT <u>Charles E. Blizzard-3617 Malden Ave.</u> <u>Husband</u>	
18. <u>571.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Liver Failure</u> (B) <u>Probable Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>581.0 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-21</u> 19 <u>68</u> to <u>4-1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-1</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sam LeBauer MD</u>		23B. DATE SIGNED <u>4-1</u>		23C. PHYSICIAN'S NAME (Type) <u>Sam LeBauer MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/5/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. ADDRESS <u>Md.</u>		24F. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>	
24G. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24H. FUNERAL DIRECTOR <u>Austin E. Donovan-3818 Roland Ave.</u>		24I. ADDRESS <u>3818 Roland Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3657</u>	
C-452		68-3657		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES CLINGERMAN</u>		2. DATE AND HOUR OF DEATH <u>3/31/68</u> <u>13:05 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HANCOCK</u> C. CITY OR TOWN <u>HANCOCK</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>RURAL 1</u>			
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/06</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ORCHARD</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SIMON CLINGERMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZA LEASURE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>170.12.5670</u>		17. INFORMANT <u>ETHEL P CLINGERMAN RURAL 1 HANCOCK</u>	
18. <u>532.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HEMORRHAGE</u> <u>ASPIRATION</u> <u>BLEEDING DUODENAL ULCER</u>		CAUSE OF DEATH <u>PNEUMONIA</u> <u>HEMORRHAGE</u> <u>ASPIRATION</u> <u>BLEEDING DUODENAL ULCER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>8 DAYS</u> <u>8 DAYS</u>	
19. <u>541.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>ARTERIO SCLEROSIS</u>				YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> 19 <u>68</u> to <u>3/31</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3/31</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Charles M. Harrison MD</u>		23B. DATE SIGNED <u>3/31/68</u>		23C. PHYSICIAN'S NAME (Type) <u>CHARLES M. HARRISON MD</u>	
23D. ADDRESS <u>UNIV. HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>APR 4 1968</u>	
24C. NAME of CEMETERY or CREMATORY <u>FAIRVIEW</u>		24D. LOCATION (City, town, or county) (State) <u>BEDFORD COUNTY PENNA.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Howard J. Young Hancock MD</u>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
B-361 68-3658 CERTIFICATE OF DEATH									
REG. NO. 68-3658									
BIRTH NO.									
1. NAME OF DECEASED <b>EVERETT CHARLES BUTTERFIELD</b>					2. DATE AND HOUR OF DEATH <b>3-29-68 10 A.M.</b>				
(Type or Print) <b>E. CHARLES BUTTERFIELD</b>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSP.</b>					A. STATE <b>MD.</b>				
					B. COUNTY <b>N. Miami Beach, Fla.</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <b>BALTIMORE</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>V-08</b>	
					E. STREET AND NUMBER <b>UNKNOWN (LIVED 3 WEEKS IN CITY)</b>				
5. SEX <b>M</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 17, 1928</b>		9. AGE (In years last birthday) <b>39</b>		If Under 1 Yr. Months Days	
		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK &amp; CHAUFFEUR UNEMPLOYED</b>					11. BIRTHPLACE (State or foreign country) <b>WINDSOR, VT.</b>				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>JOHN BUTTERFIELD</b>					14. MOTHER'S MAIDEN NAME <b>MAE MERKLE</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>J.E. BUTTERFIELD</b>		
							ADDRESS <b>N. MIAMI BEACH</b>		
					<b>1615 N.E. 159TH ST.</b>		<b>FLORIDA</b>		
18. <b>571.0 I</b>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					APPROXIMATE PERIOD BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE <b>Acute hepatic insufficiency</b> <b>Days</b>				
					DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					(B) <b>Nutritional cirrhosis</b> <b>Years</b>				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <b>Chronic alcoholism &amp; deficient diet</b> <b>Years</b>				
<b>581.1 II</b>					<b>R/o Alcoholic gastritis; R/o Mallory-Weiss</b> <b>Days</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3-28-68</b> 19 <b>68</b> to <b>3-29-68</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3-29-68</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Bruce W. Pfeffer, M.D.</b>								23B. DATE SIGNED <b>3-29-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRUCE W. PFEFFER, M.D.</b>								23D. ADDRESS <b>Mercy Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>			24B. DATE <b>4/3/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CREMATORY</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>			

My dear Mr. [unclear]  
[unclear] [unclear]  
[unclear] [unclear]  
[unclear] [unclear]

With best regards

Yours truly,  
[unclear]  
[unclear]

Yours truly,  
[unclear]  
[unclear]

F-460

68-3659

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3659

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES T. FOWLER

2. DATE  
OF  
DEATHKnown ☐ Month Day Year  
Estimated ☒ March 31, 1968

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

4204 Kenwood Avenue

3. DATE  
PRONOUNCED DEAD

March 31, 1968

Hour

9:40 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

Nov. 6, 1889

10. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4204 Kenwood Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James H. Fowler

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cashier

14B. KIND OF BUSINESS OR INDUSTRY

Race Track

15. MOTHER'S MAIDEN NAME

Elizabeth Maxwell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-07-5351

18. INFORMANT

ADDRESS

Mrs. Bessie Woeller-4203 Kenwood Ave.-21206

19.

571.8

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Fatty Alteration of Liver

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

581.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-3-68

24C. NAME OF CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 4 1968

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

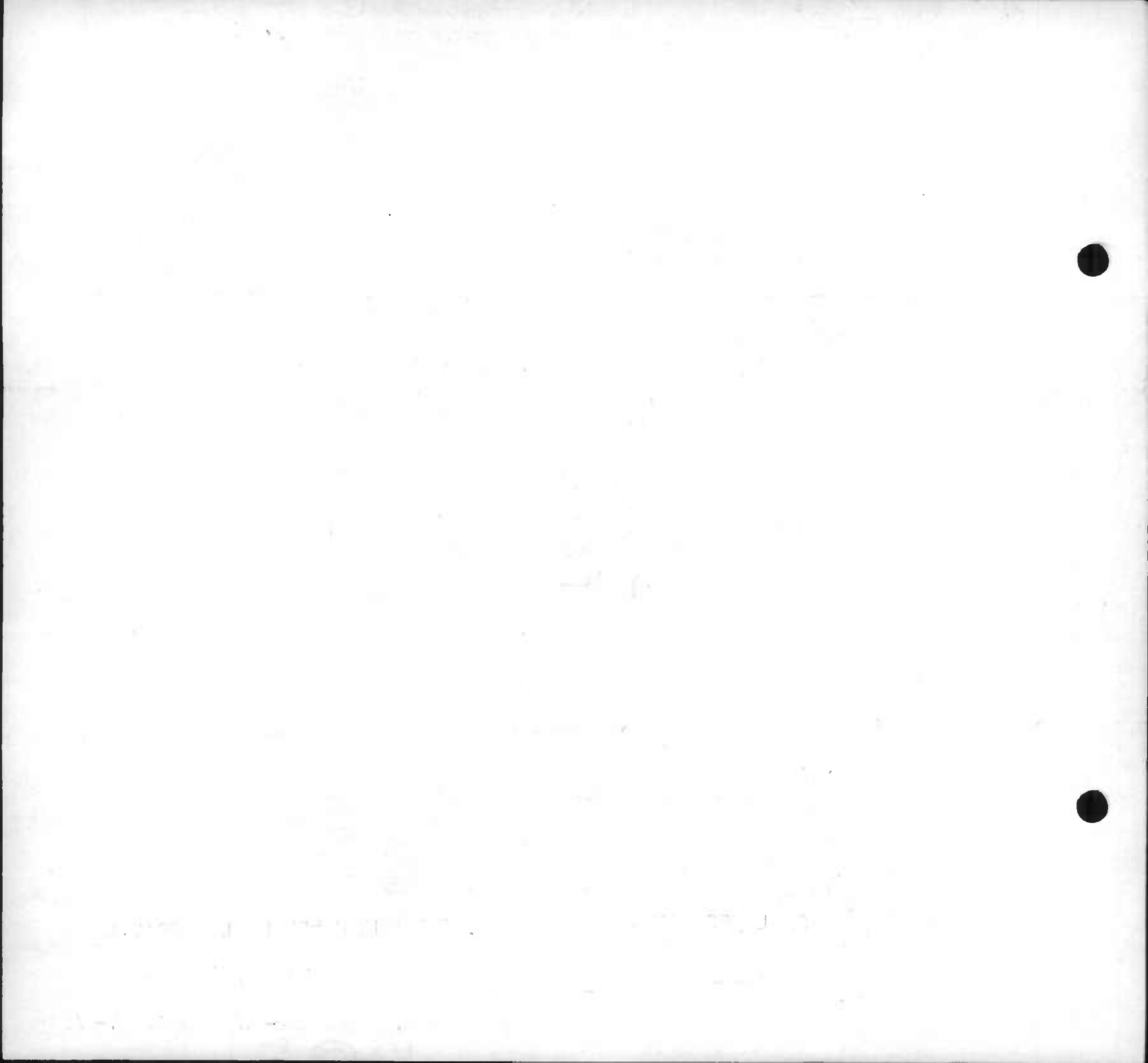
John C. Miller Inc-6415 Belair Rd.-21206



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3660</b>
<b>W-630</b>		<b>68-3660</b>		<b>CERTIFICATE OF DEATH</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WARD J. ROBERT</b>		
2. DATE AND HOUR OF DEATH <b>3-31-68 10 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>1614 FELDBROOK RD.</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04-13-00</b>	9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES M. WARD</b>		
14. MOTHER'S MAIDEN NAME <b>JOHANNAT. RYAN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>212-01-6683</b>		17. INFORMANT <b>J. Gilbert Ward - Box 76 E. Rt. #1</b>		
ADDRESS <b>Stevensville, Md.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) <b>Staphylococcal osteomyelitis</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Infected Femoral head fracture</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Malnutrition, Polydipsia, Renal failure</b>				
19A. DATE OF OPERATION <b>2-11-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture, femoral head</b>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>at home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1614 FELDBROOK BALT. MD. 53-00</b>
21D. TIME OF INJURY (APPROX.) <b>Feb. 9 1968 10 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Sleep &amp; hurt his @ hip</b>
22. I certify that (I) (this hospital) attended the deceased from <b>2-10-68</b> to <b>3-31-68</b> and that (I) (we) last saw the deceased alive on <b>3-31-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Raul Desquitado</b>		23B. DATE SIGNED <b>3-31-68</b>		23C. PHYSICIAN'S NAME (Type) <b>RAUL V. DESQUITADO</b>
23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-4-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION <b>Baltimore, Maryland</b>	(State)
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	25C. FUNERAL DIRECTOR <b>John C. Miller Inc-6415 Belair Rd.-21206</b>		
25D. ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
B-200 68- 3661 CERTIFICATE OF DEATH									
REG. NO. 68- 3661									
1. NAME OF DECEASED (Type or Print) <i>John A. Bush</i>					2. DATE AND HOUR OF DEATH <i>April 3-68 1415 A.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2620 Washington Blvd</i>					A. STATE <i>MD</i>		B. COUNTY <i>Baltimore</i>		
					C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>2620 Washington Blvd</i>									
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-6-1912</i>		9. AGE (In years last birthday) <i>56</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tavern Owner</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Tavern</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Ignatius Bush</i>					14. MOTHER'S MAIDEN NAME <i>Adele Dumoka</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes M.W. 2</i>			16. SOCIAL SECURITY NO. <i>214-61585</i>		17. INFORMANT <i>Mildred F. Bush</i>				
					ADDRESS <i>2620 Washington Blvd</i>				
18. CAUSE OF DEATH <i>420.9 I</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CORONARY OCCLUSION ?</i>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) CORONARY HEART DISEASE 10 YRS</i> <i>(B) SEVERE RHEUMATIC HEART 10 YRS</i>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II DISPERSE</i>									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7/17/67</i> 19 to <i>4/3/68</i> 19, that (I) (we) last saw the deceased alive on <i>3/20/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Herbert W. App</i>					23B. DATE SIGNED <i>4/3/68</i>				
23C. PHYSICIAN'S NAME (Type) <i>Herbert W. App</i>					23D. ADDRESS <i>4804 FREDERICK AVE. BALTIMORE 29, MD. - MI 4-3655</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>4/8/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto Nat. Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 4 1968</i>			25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Thomas J. Kennedy</i>				
					ADDRESS <i>1600 Frederick St</i>				

1912 May 10

2nd day of May

2nd day of May

1912

2nd day of May

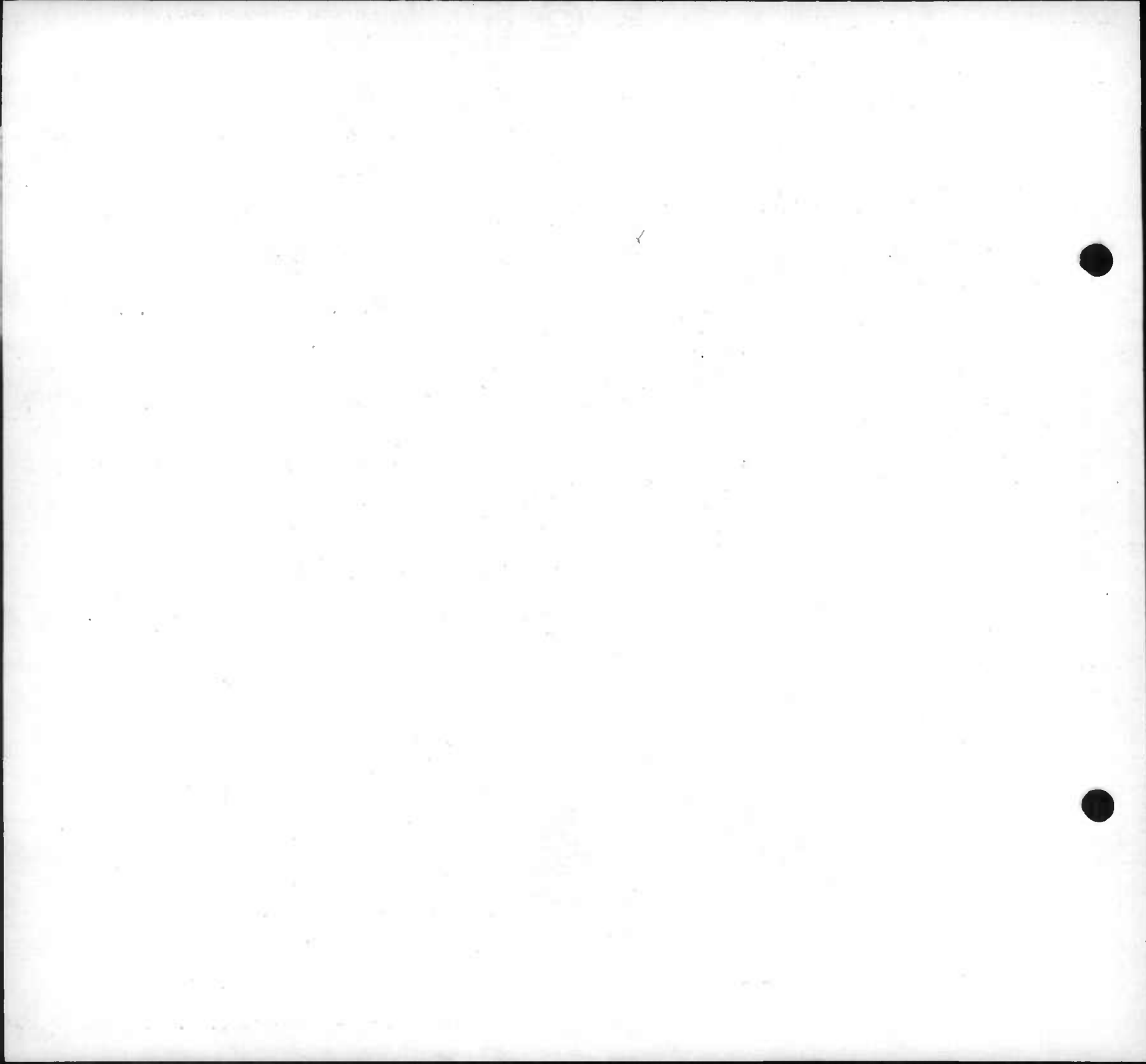
1912 May 10

1912 May 10

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

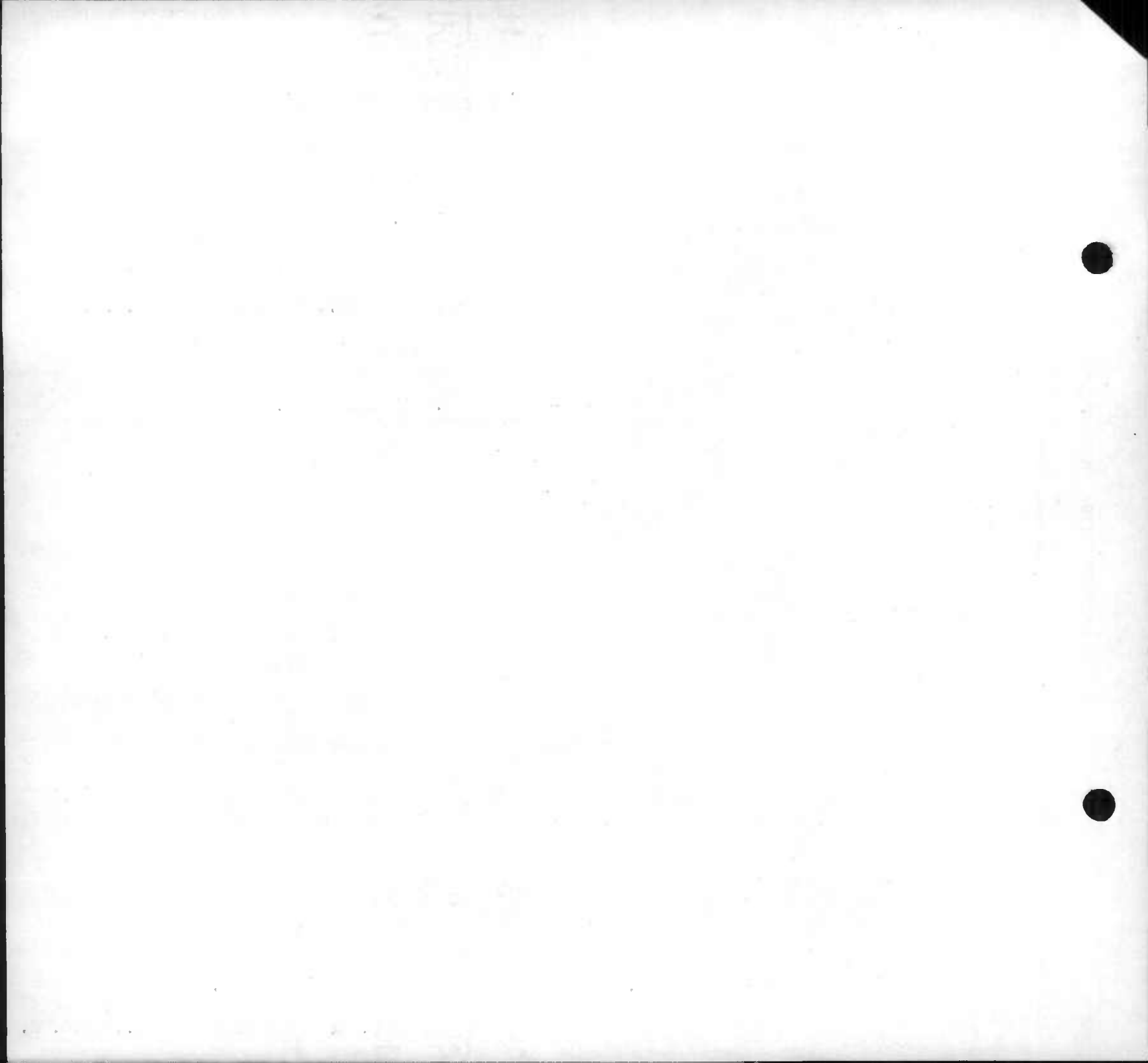
B-650		68-3662		CITY HEALTH DEPARTMENT		REG. NO. 68-3662	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CORNELIA L. BROWN			
2. DATE AND HOUR OF DEATH 4/2/68				5.30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland #21224				E. STREET AND NUMBER CHW FRANKLIN ST. 21201 007			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/29	9. AGE (In years last birthday) 38	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Clarksburg, W. Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HUGH Lewis				14. MOTHER'S MAIDEN NAME LUCY STEPTOE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 234-46-4735			
17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Maryland 21224				ADDRESS #			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 250.9 I CHRONIC RENAL FAILURE UNKNOWN ETIOLOGY. 6 months				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES - (CHRONIC) PYELONEPHRITIS 6 months			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHF 6 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/27/68 19 68 to 4/2 19 68, that (I) (we) last saw the deceased alive on 4/2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. Anderson				23B. DATE SIGNED 4/2/68			
23C. PHYSICIAN'S NAME (Type) GRACIELA S. MARION				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL REMOVAL (Specify) Burial		24B. DATE 4-6-68		24C. NAME of CEMETERY or CREMATORY Stonewall		24D. LOCATION (City, town, or county) (State) Clarksburg, W. Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 4 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Lynch Stacy - Clarksburg, W. Virginia		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

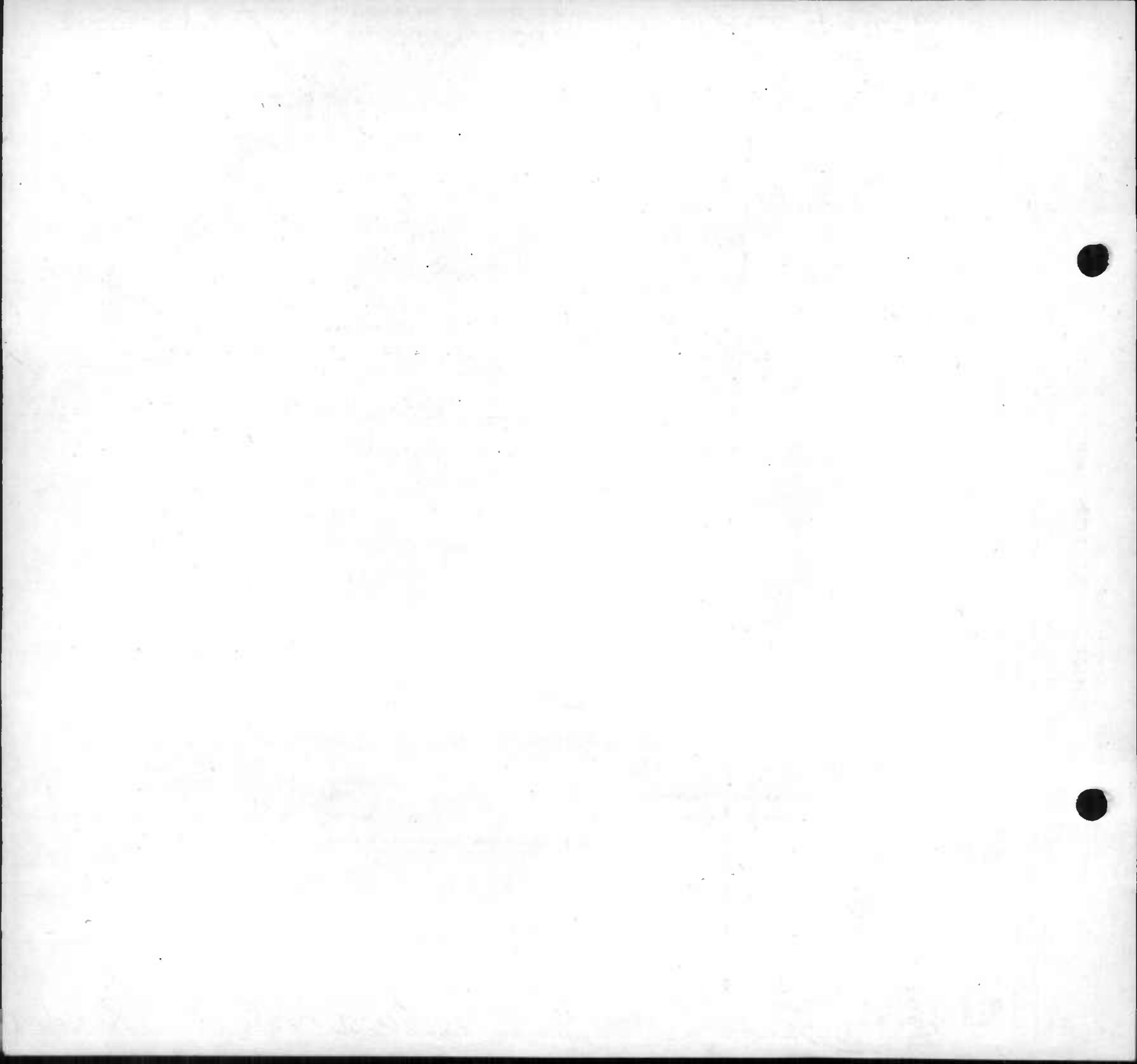
BALTIMORE CITY HEALTH DEPARTMENT				68- 3663	
BIRTH NO. <span style="float: right;">A-450</span>				68- 3663	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Madison Crencha Allen, Sr.				March 31, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland	
00 1410 McCulloh Street				C. CITY OR TOWN D. INSIDE CITY LIMITS	
2107 E. Cold Spring Lane				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
June 24, 1890		77		Minister	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Buckingham Co., Virginia		U.S.A.		Carey Allen	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Virginia Winston		Yes WWI		224-60-3559A	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
Mrs. Wilhelminia S. Garner - Same		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
413.0 I		(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		443X II	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF:		20A. AUTOPSY? (Yes or No)	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/11/68 to 3/31/68, that (I) (we) last saw the deceased alive on 3/30/68 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
W Garner		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
W GARNER		1005 W Lafayette Ave		24A. BURIAL CREMATION, REMOVAL (Specify)	
Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
4-4-68		Mt. Nebo Baptist		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 4 1968		Charles R. Law		ADDRESS	
802 Madison Ave., Balto. Md.		25D. DATE		25E. NAME	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3664</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">A-654</span> <span>68- 3664</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. <span style="float: right;">1</span>					
1. NAME OF DECEASED (Type or Print) <b>WALTER CLINTON ARNOLD</b>			2. DATE AND HOUR OF DEATH <b>3/26/68 10<sup>30</sup> A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>99.00 52-00</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b>			C. CITY OR TOWN <b>ODENTON</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
38 BALTIMORE, MARYLAND			E. STREET AND NUMBER		
5. SEX <b>M</b>	6. RACE <b>CAUC.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/22/08</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAIRY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>dairy</b>	11. BIRTHPLACE (State or foreign country) <b>TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WALTER ARNOLD</b>			14. MOTHER'S MAIDEN NAME <b>MARY ARNOLD * NOT KNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>WIFE MARY ARNOLD SAME</b>		
18. <b>5-19-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <b>Respiratory Arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>COPD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
18. <b>5-27-2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>3/25</b> 19 <b>68</b> to <b>3/26</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/26</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Kaliner</b>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-26-68</b>
23C. PHYSICIAN'S NAME (Type) <b>Michael Kaliner MD</b>			23D. ADDRESS <b>1200 W. 12th St. Baltimore, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3-29-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Sanage Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Sanage Md</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Finken</b>	25C. FUNERAL DIRECTOR ADDRESS <b>William J. Danielson Laurel Md</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 3665</span>
D-500		68- 3665		CERTIFICATE OF DEATH
BIRTH NO. <span style="font-size: 1.2em;">171-211</span>				
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">RALPH DEEM</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3-29-68</span> <span style="font-size: 1.2em;">5:10 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">H2 SINAI Hosp.</span>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Howard</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Jessups</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">RT 175 Jessups</span>	
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Aug 16 1910</span> 9. AGE (In years last birthday) <span style="font-size: 1.2em;">57</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">supervisor</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Patient Institute</span>		11. BIRTH PLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Van Deem</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Hattie Trembley</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">2-46-2100</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Ralph Deem, Jessups Md.</span> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">HEPATIC pulmonary</span> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">+ bony metastasis</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1-2 months</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">Fibrosarcoma @ Shoulder 7-8 yrs</span>				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">1977.2 II</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2-20</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">3-29</span> 19 <span style="font-size: 1.2em;">68</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3-29-68</span> 19 <span style="font-size: 1.2em;">68</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span> DEGREE			23B. DATE SIGNED <span style="font-size: 1.2em;">3-29-68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Edith C. Galvez</span> DEGREE			23D. ADDRESS <span style="font-size: 1.2em;">SINAI Hosp of Balto.</span>	
24A. BURIAL CREMATION REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">4-1-68</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">MemPark Cemetery Md</span>	24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 4 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jarboe, MA</span>		
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">DelWitt Danielian Laurel Md</span>			ADDRESS	

Jan 10 1892

My dear Mr. [unclear]

I have

just received the [unclear] [unclear] [unclear]

to [unclear] [unclear]

Dear

Very truly

Yours

[unclear]

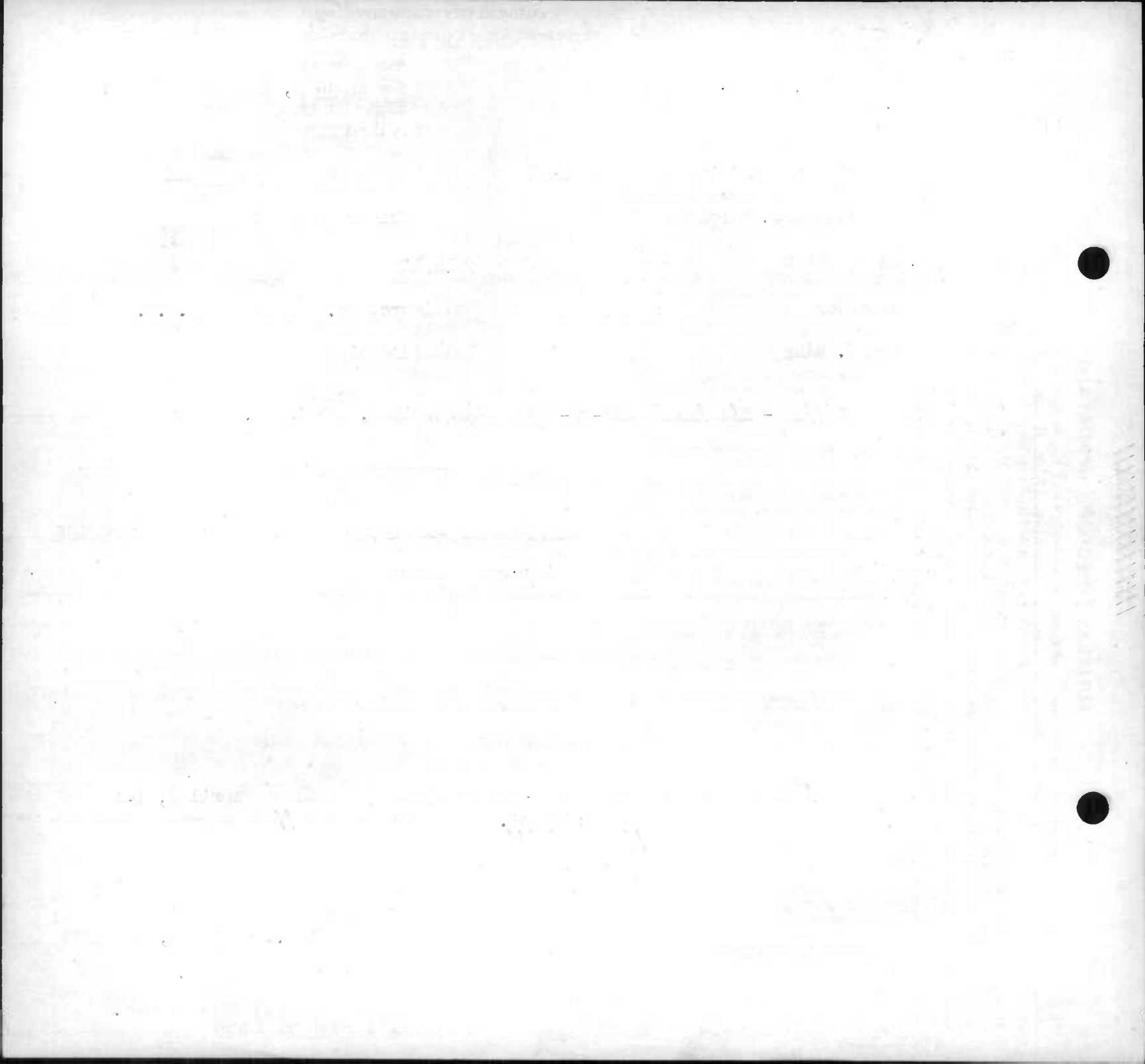
[unclear]

[unclear]

# FUNERAL DIRECTOR: IMPORTANT

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K-520		68-3666		CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68-3666	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>KING, JOHN ALOYSIUS, SR</b>				2. DATE AND HOUR OF DEATH <b>April 1, 1968 10:50 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3221 Brendan Ave</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John J. King</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Quinn</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1/7/44 - 1/26/46</b>		16. SOCIAL SECURITY NO. <b>212-05-3359</b>		17. INFORMANT <b>Records VA Hospital, Baltimore, Maryland 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.9 I</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia</b> (B) <b>Cardiovascular accident</b> (C) <b>Diabetes Mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3 months</b> <b>several years</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>260x II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>March 23rd 1968</b> to <b>April 1, 1968</b> and that (1) (we) last saw the deceased alive on <b>April 1st. 1968</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (1) (view) the body after death.		23A. SIGNATURE <b>John C. Bohlen M.B. DEGREE</b>		23B. DATE SIGNED <b>4/2/68</b>					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



FOR APPROVAL

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-120		68-3667		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3667	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>NOVAK, FRANK LOUIS</b>			
2. DATE AND HOUR OF DEATH <b>April 1, 1968</b>				3:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Route 16, Box 409 A</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/94</b>	9. AGE (In years last birthday) <b>73</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter &amp; Paperhanger</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James F. Novak</b>				14. MOTHER'S MAIDEN NAME <b>Antoinette Roskey</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5/29/18 - 6/11/19</b>				16. SOCIAL SECURITY NO. <b>219-01-46-49</b>			
17. INFORMANT <b>Records</b>				ADDRESS <b>VA Hospital, Baltimore, Maryland 21218</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>4/2/94 x 1/85 x</b> <b>Coronary Sclerosis with coronary heart disease and chronic heart failure and pulmonary edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Advanced carcinoma of bladder</b> <b>Uremia, chronic pyelonephritis with abscess of right kidney</b> <b>9/c fracture right femur</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>			
20A. AUTOPSY? (Yes or No) <b>Yes</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>2</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>			
21C. WHERE DID INJURY OCCUR? <b>3900 Loch Raven Blvd. Baltimore, Md.</b>				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>3/28/68 12:50pm</b>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? <b>Patient ambulating in corridor on way to bathroom and slipped sustaining fracture rt. femur</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>March 5th 19 68</b> to <b>April 1st 19 68</b> , that (I) (we) last saw the deceased alive on <b>April 1st 19 68</b> and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>N. Bayadi</b>				23B. DATE SIGNED <b>4/2/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Fackema</b>				23D. ADDRESS <b>VA Hospital Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Fackema</b>			
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				ADDRESS <b>3331 Brehms Lane</b>			

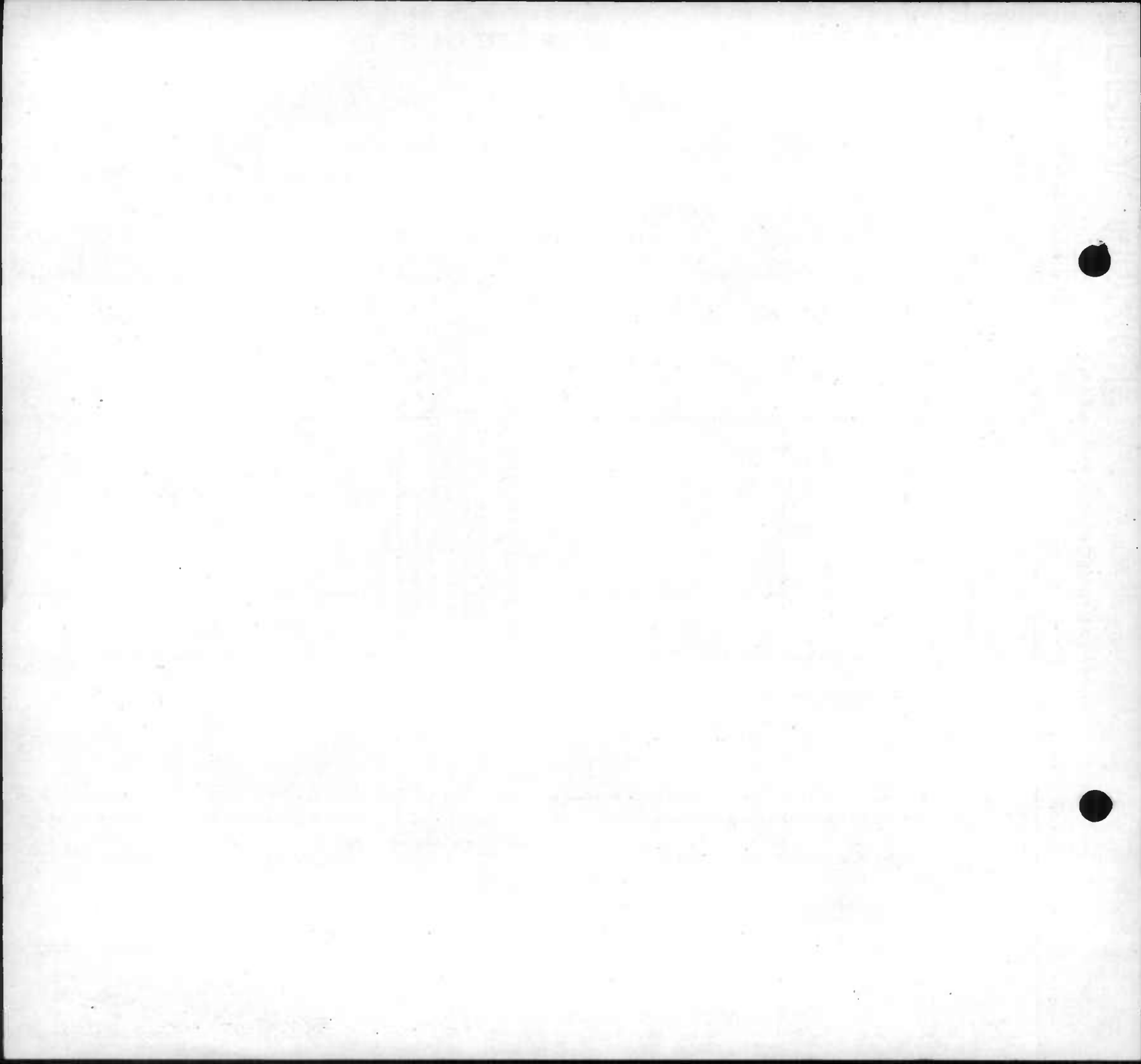
051-4



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

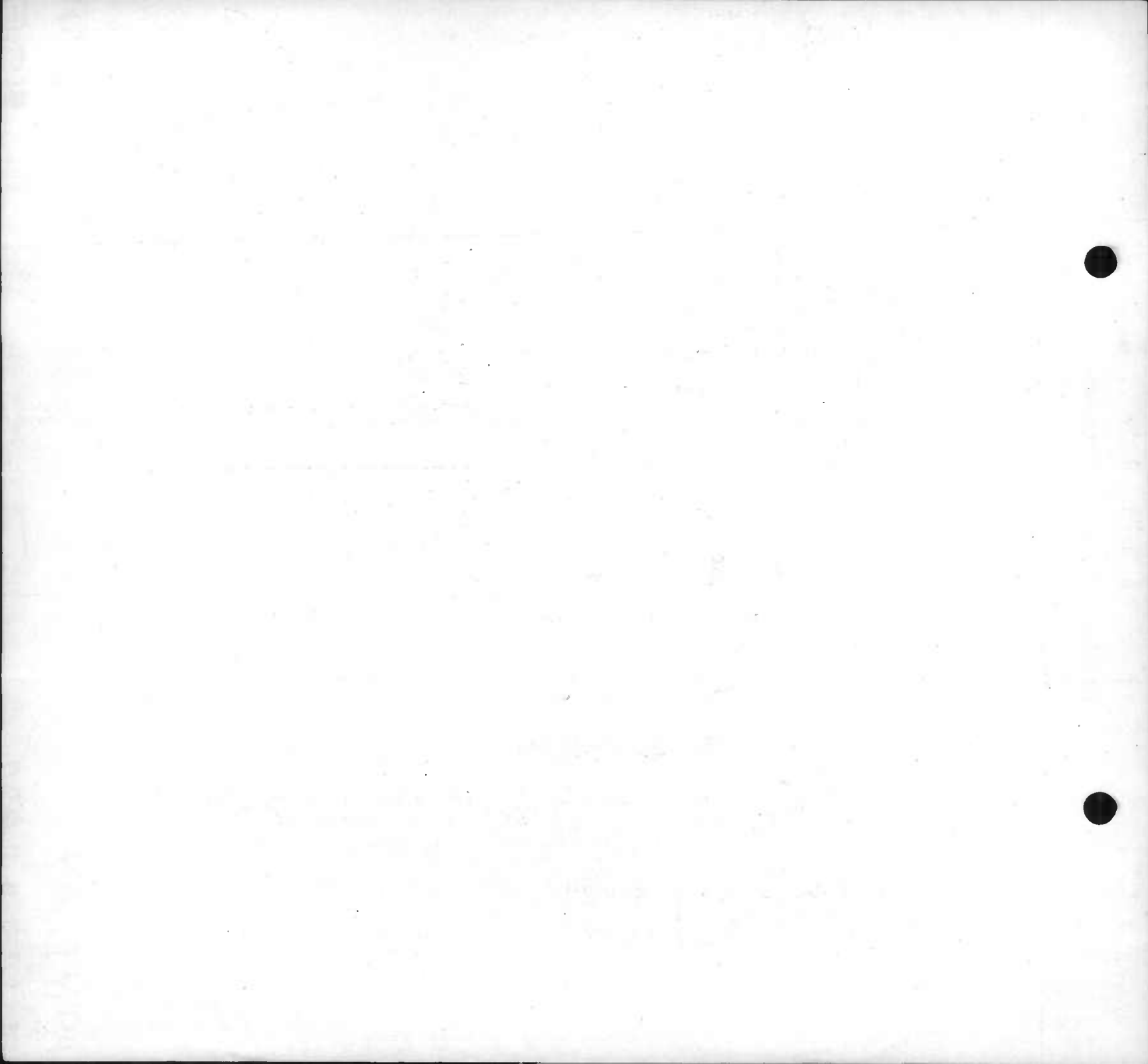
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3668	
B-653 68- 3668 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Katheline B. Brendel</u>		2. DATE AND HOUR OF DEATH <u>April 2, 1968 12<sup>55</sup> P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>27-03</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-2-05</u>		9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James I. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Mamie Hullman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-34-8259</u>		17. INFORMANT <u>WM. BRENDEN JR., 4800 WALTER AVE 21214</u>	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) <u>Carcinoma Breast (with metastasis)</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3-30-1968</u> to <u>4-2-1968</u> , that (I) (we) last saw the deceased alive on <u>4-1-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>P. L. ... M.D.</u>		23B. DATE SIGNED <u>4-2-68</u>		23C. PHYSICIAN'S NAME (Type) <u>MERCY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL - Section 7-5-68</u>		24B. DATE <u>APR 4 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>PROSPECT HILL CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>YORK, PA</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>APR 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME, BALTO., MD.</u>		25D. ADDRESS <u>4800 WALTER AVE 21214</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250 68- 3663				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3663	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Jefferson D. Jackson</u>				2. DATE AND HOUR OF DEATH <u>4/2/68</u> <u>2:5 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>8 Maryland Gen. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Box 158 Rt. 10</u>			
5. SEX <u>♂</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/86</u>		9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PILOT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Jackson</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-2928</u>		17. INFORMANT ADDRESS <u>MRS. MARY JACKSON Box 150-Rt. 10 - 21219</u>			
18. <u>4-27-41</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>433.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pneumonitis - staph</u> (B) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Atrial fib.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <u>NO</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/26/68</u> 19 to <u>4/2/68</u> 19, that (I) (we) last saw the deceased alive on <u>4/2/68</u> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ralph D. Raymond MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/2/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph D REYMOND</u>				23D. ADDRESS <u>Maryland Gen. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/5/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. OLIVET CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>			



Released By Med. Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

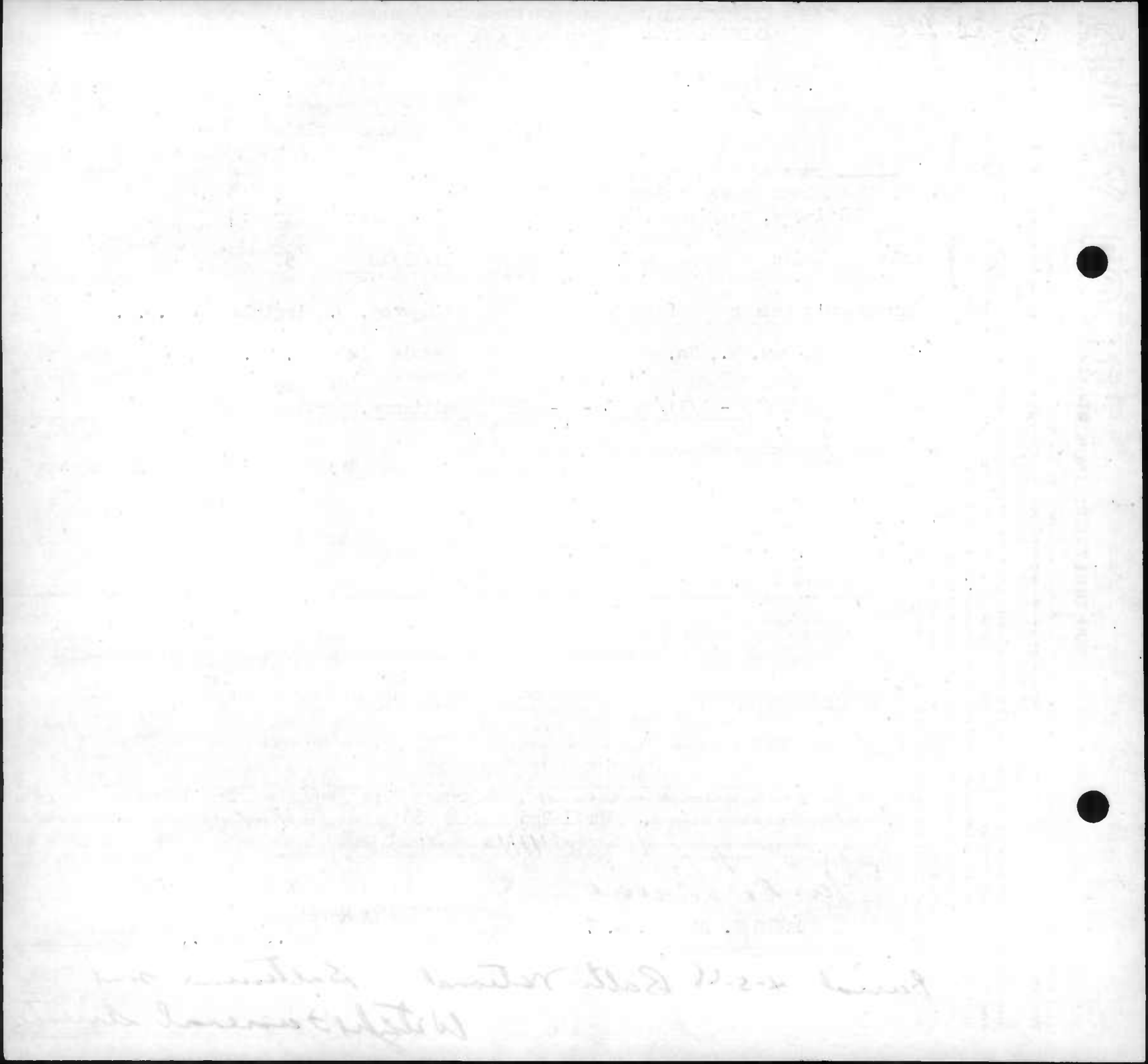
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3670	
BIRTH NO. 68-3670					
1. NAME OF DECEASED (Type or Print) <i>Noel C. McGee</i>			2. DATE AND HOUR OF DEATH <i>4-2-68</i> <i>2<sup>21</sup> P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>			A. STATE <i>Baltimore</i> B. COUNTY <i>Baltimore City</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore City</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1200 Valley St</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 22/1890</i>	9. AGE <i>77</i> years last birth <i>yes</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Machine Operator</i>	11. BIRTHPLACE (state or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Patrick J. McGee</i>			14. MOTHER'S MAIDEN NAME <i>Mary Donellan</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-18-7401</i>	17. INFORMANT <i>Mrs. Stephanie Bandholtz</i>		ADDRESS <i>Md. Pasadena</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>410.9+E 1887X</i>			19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial infarction (R coronary artery)</i> <i>ASCVD + old H.E.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>4/20/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>	20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Little Sister of the poor</i>		
21D. TIME OF INJURY (APPROX.) <i>March 31 68 2pm</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>She felt as if had a fx of left hip</i>		
22. I certify that <i>X</i> (this hospital) attended the deceased from <i>3/31/68 6:15 pm</i> to <i>4/2/68 2:20 pm</i> 19 <i>68</i> , that (I) <i>we</i> last saw the deceased alive on <i>12/24/67</i> 19 <i>67</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Rahimi M.D.</i>			23B. DATE SIGNED <i>4/2/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Abbas RAHIMI M.D.</i>			23D. ADDRESS <i>Mercy Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/5/68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>
25A. DATE REC'D BY HEALTH DEPT. <i>APR 4 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Philip Herwig Sons Orleans St</i>	



FUNERAL DIRECTOR: IMPORTANT

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68- 3671				CITY HEALTH DEPARTMENT		REG. NO. 68- 3671	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BUCKLEW, Lawrence Roy</b>		2. DATE AND HOUR OF DEATH <b>April 2, 1968</b>		<b>2:20 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>2920 Freeway Street</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/11/10</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter's helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Kingwood, W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Bucklew, W., Va.</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Dixon W. Va.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>236-14-1432</b>		17. INFORMANT <b>VA Hosp Records</b>		ADDRESS <b>Baltimore, Maryland 21218</b>	
18. <b>011.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>002.1 II</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Tuberculosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? 2 months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>February 20th 1968</b> to <b>April 2nd 1968</b> , that (I) (we) last saw the deceased alive on <b>April 2nd 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>David N. Marine</i>						23B. DATE SIGNED <b>4/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID N. MARINE, M.D.</b>				23D. ADDRESS <b>VA Hospital</b> <b>3900 Loch Raven Blvd., Balto., Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore and</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Wright Funeral Directors</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

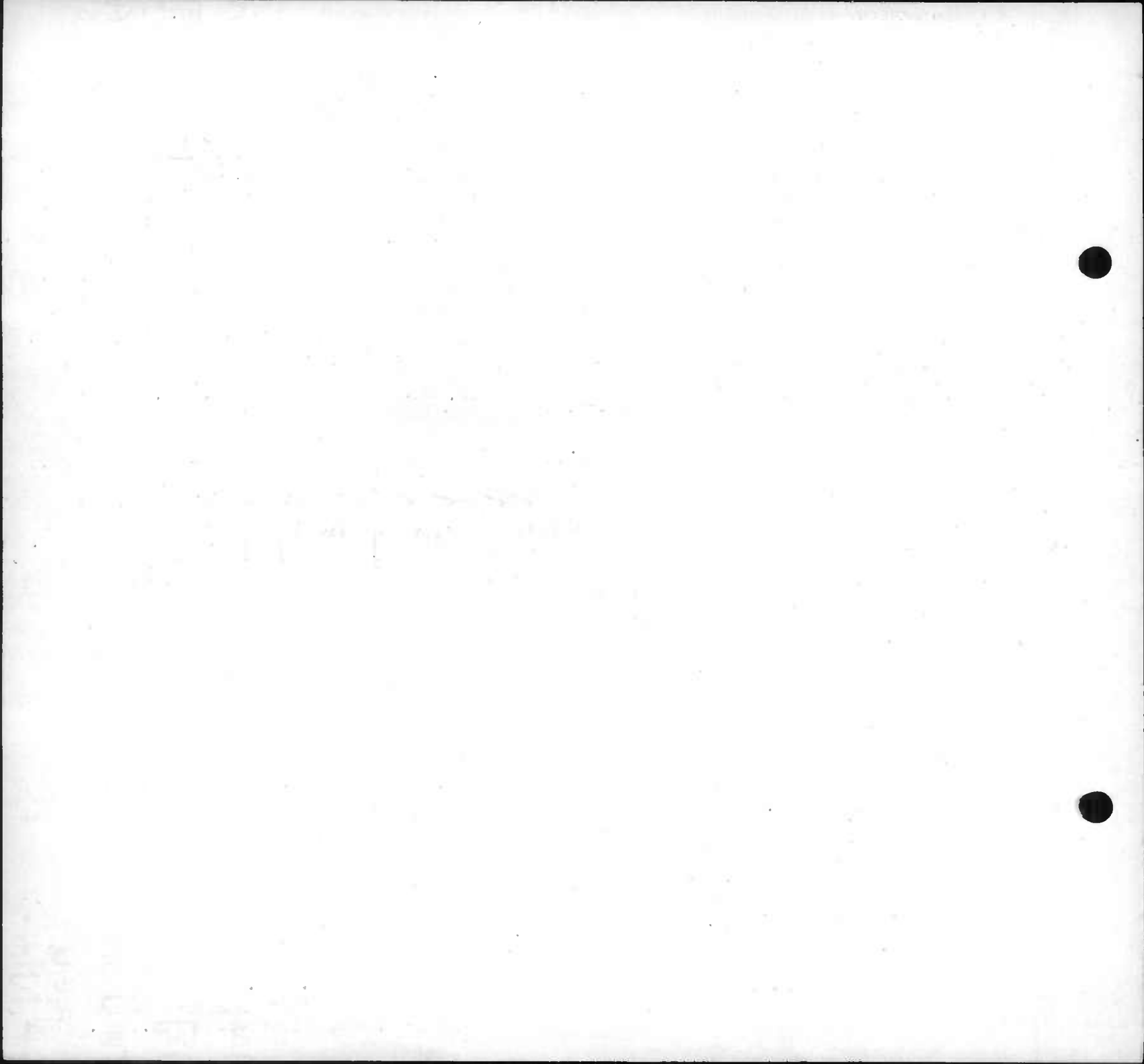
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68-3672

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Wiley R. Swietzer</b>		2. DATE AND HOUR OF DEATH <b>4/1/68 10:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
5. SEX <b>M</b> 6. RACE <b>W</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>8/2/18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUTCHER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT CUTTING</b>		9. AGE (In years last birthday) <b>50</b>
13. FATHER'S NAME <b>John W. Swietzer</b>			14. MOTHER'S MAIDEN NAME <b>Belle Boyer</b>		11. BIRTHPLACE (State or foreign country) <b>Roanoke, VA.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>226-12-1291</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
18. <b>157.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Adenocarcinoma</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 mos</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adenoma of body of pancreas</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? <b>NONE</b>	
21D. TIME OF INJURY (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NONE</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3/23 1968</b> to <b>4/1 1968</b> , that (I) (we) last saw the deceased alive on <b>4-1 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>F. J. Zorick MD</b>				23B. DATE SIGNED <b>4/1/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. J. ZORICK MD</b>				23D. ADDRESS <b>MD. General Hosp., Balto.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>			
25B. NAME OF REGISTRAR <b>John E. Farber</b>		25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>			



68- 3673

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3673

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>THOMAS J. KASPRZAK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 3, 1968</b>		Hour <b>1:10 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1917 Fleet Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 3, 1968</b>		Hour <b>1:10 P.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>12/29/01</b>		10. AGE (In years last birthday) <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Stanislaus Kasprzak</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2-03</b>
15. MOTHER'S MAIDEN NAME <b>Josephine Stacharowski</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW II WW II</b>		17. SOCIAL SECURITY NO. <b>216-01-3058</b>
18. INFORMANT <b>Mr. Sylvester Kasper, 2404 Hudson St.</b>		19. CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		20. DATE OF OPERATION <b>0</b>
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>4/22.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?</b>		23. DATE OF OPERATION <b>0</b>
24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>
24D. LOCATION (City, State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>
25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		25D. DATE SIGNED <b>4-3-68</b>		25E. SIGNATURE <b>Ronald N. Kornblum, M.D.</b>

MEDICAL CERTIFICATION

Grand N/land

F. 652

68-- 3674

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-- 3674

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>EDWARD FRANK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 1, 1968 11:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 1, 1968 11:30 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>28-11</b>	
9. DATE OF BIRTH <b>2-13-1945</b>		10. AGE (In years lost birthday) <b>XX 23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintainance</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>212-50-2185</b>	
15. MOTHER'S MAIDEN NAME <b>Lutman</b>		18. INFORMANT ADDRESS <b>John M. Frank-4810 Liberty Hghts. Avenue</b>	
19. <b>E 816.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cranio-Cerebral Injury</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. <b>E 823.4 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22D. TIME OF INJURY (APPROX.) <b>3/25/68 2:55 A.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>subj. failed to negotiate curve, went off road, struck a pole</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>4/2/68</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		ADDRESS <b>4600 Liberty Hghts.</b>	

N 854X

1-10-1975

John L. Rice, Jr.

Washington

USA

1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975

1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975

John L. Rice, Jr.

Washington

1-10-1975

1-10-1975

1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975, 1-10-1975

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3675	
68- 3675					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHMIELEWSKI MR STEPHEN (STEPHAN)</b>		2. DATE AND HOUR OF DEATH <b>4/3/1968 11-15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>1816 Fleet St</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-1887</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD MACH. RAILROAD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>STANISLAW CHMIELEWSKI</b>		
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		
16. SOCIAL SECURITY NO. <b>705-05-0912</b>		17. INFORMANT <b>THEODORE CHMIELEWSKI</b> ADDRESS <b>1816 FLEET ST. BALTO. MD. 21231</b>			
18. <b>590.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremic Acidosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chr. Pyelonephritis</b> <b>G.I. bleeding</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-16-1968</b> to <b>4-3-1968</b> , that (I) (we) last saw the deceased alive on <b>4-3-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jose S. Marsag</b> DEGREE				23B. DATE SIGNED <b>4-3-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jose S. Marsag</b> DEGREE				23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/6/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. COUNTY MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>W. FIALKOWSKI</b> ADDRESS <b>2007 EASTERN AVE. BALTO. MD. 21231</b>			

(1975)

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10-11-1975

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3676</span>	
<div style="display: flex; justify-content: space-between;"> <span>C-636</span> <span>68- 3676</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ROBERT CARTER</u>		2. DATE AND HOUR OF DEATH <u>4/1/68</u> <u>12:15</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>PRINCE GEORGES</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 U. of MD. HOSP.</u>			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>2208 CREM AVE.</u> <u>21217</u>		
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/9/23</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Smoking Gunner</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>ROBERT CARTER</u>		14. MOTHER'S MAIDEN NAME <u>KATE Jenney</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>228-18 1446</u>		17. INFORMANT <u>Mrs. Jean Nelson 2205 Creek Lane</u>	
18. <u>205.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>GRAM - SKECH</u> (B) <u>ISCHEMIC ABSCESS</u> (C) <u>CHRONIC MYELOGENOUS LEUKEMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <u>204.1</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>3/20</u> 19 <u>68</u> to <u>4/1</u> 19 <u>68</u> , that <u>(I)</u> (we) lost saw the deceased alive on <u>4/1</u> 19 <u>68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>William Bloom</u>				23B. DATE SIGNED <u>4/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM BLOOM</u>				23D. ADDRESS <u>Richmond Va.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>4/6/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Richmond Va.</u>		24E. FUNERAL DIRECTOR <u>Joseph L. Rivers 2222 W. North Ave. Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbanks</u>		25C. ADDRESS	

Shirley, 1900

My dear Mr. [illegible]

Yours truly

[illegible signature]

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 83 21 7 068 3677
M-213 68-3677				MC FADDEN, CATHERINE 5
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CATHERINE MCFADDEN</b>		
2. DATE AND HOUR OF DEATH <b>April 2, 1968 8:30 P.</b>		M. <b>9.05</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>1433 HOMESTEAD STREET</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-2-32</b>	9. AGE (In years last birthday) <b>35</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>George GEORGE MILLER</b>		
14. MOTHER'S MAIDEN NAME <b>NORA STOVER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Phyllis Miller</b> ADDRESS <b>1433 Homestead</b>		
18. <b>734.0 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PROGRESSIVE SYSTEMIC SCLEROSIS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <b>2</b>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1968</b> to <b>MAX April 2, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>David J. Shaw</b>		23B. DATE SIGNED <b>4/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>DAVID J. SHAW, M.D.</b>
23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>April 6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Charlotte N.C.</b>		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>		25C. FUNERAL DIRECTOR <b>Frank T. Childers</b> ADDRESS <b>1129 N. Charles</b>

W.C.

W.C.

W.C.

W.C.

W.C.

W.C.

W.C.

W.C.

W.C.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3678

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RONALD A. WARD THOMAS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>March 30, 1968</b> 11:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1301 St. Paul St. Apt. 62</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 1, 1968</b> 8:10 P.M.	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>March 4, 1946</b> 22		10. AGE (in years lost birthday) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Male-Nurse</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-42-0463</b>	
15. MOTHER'S MAIDEN NAME <b>Loretta Ward</b>		18. INFORMANT ADDRESS <b>Mrs. Loretta Thomas 1919 Ridgehill Ave</b>	
19. <b>E950.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Overdose of Barbiturates</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22D. TIME OF INJURY (APPROX.) <b>bet. 3/30/68 11:00 A. &amp; 4/1/68 8:10 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? <b>1301 St. Paul St. Apt. 62</b>		22F. HOW DID INJURY OCCUR? <b>Ingested an overdose of sleeping pills.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/2/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	

Handwritten signature or mark, possibly reading "J. J. [illegible]".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 3678 CERTIFICATE OF DEATH					REG. NO. 68- 3679				
BIRTH NO. <u>B-635</u>					1. NAME OF DECEASED (Type or Print) <u>Samuel P. Barton</u>				
2. DATE AND HOUR OF DEATH <u>April 3, 1968</u> <u>9:45 A</u> M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3036 Kenyon Ave.</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY				
5. SEX <u>male</u>					6. RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>Sept. 20, 1908</u>				
9. AGE (In years last birthday) <u>59</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>				
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Harry Barton</u>					14. MOTHER'S MAIDEN NAME <u>Amelia Kendall</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>213-03-1923</u>				
17. INFORMANT <u>Mrs Mary T Barton</u>					ADDRESS <u>Same</u>				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Mediastinal tumor</u> <u>type undetermined</u>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>231X II</u>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>None</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <u>None</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>14 January</u> 19 <u>68</u> to <u>present</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2 April</u> 19 <u>68</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE <u>Arthur G. Siwinski</u>					23B. DATE SIGNED <u>3 April 1968</u>				
23C. PHYSICIAN'S NAME (Type) <u>Arthur G. Siwinski, M.D.</u>					23D. ADDRESS <u>8 36 Park Avenue, Baltimore, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>4/6/68</u>				
24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 4 1968</u>					25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>				
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc</u>					ADDRESS <u>Baltimore, Md.</u>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		68- 3680		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3680		
CERTIFICATE OF DEATH								
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH						
Jane F Haase		April 3, 1968		11:00 A.		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>96 CERTIFICATE AMENDED</b> Ardleigh Nursing Home				A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8420 Oakleigh Ave Rd				
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days			If Under 24 Hrs. Hours Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1873 Jan. 12, 1872	95 96				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife					Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
George Croucher				Margaret Dumphy				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No		215-54-335J1		Mrs Marie Lam		Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				
412.9 I								
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF				
				Arteriosclerotic cardio-vascular disease 15 yrs.				
				(B) Senile changes 3 yrs.				
				(C).....				
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
0						No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from March 23, 19 68 to April 3, 19 68, that (I) (we) last saw the deceased alive on April 3, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE				23B. DATE SIGNED				
Lloyd E Saylor				April 4, 1968				
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS				
Lloyd E Saylor M.D.				3902 Greenmount Ave				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial		4/6/68		Parkwood		Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS				
APR 4 1968		Robert E. Saylor		Leonard J Ruck Inc. Baltimore, Md				

4/9/68 - Correction form from funeral difector.

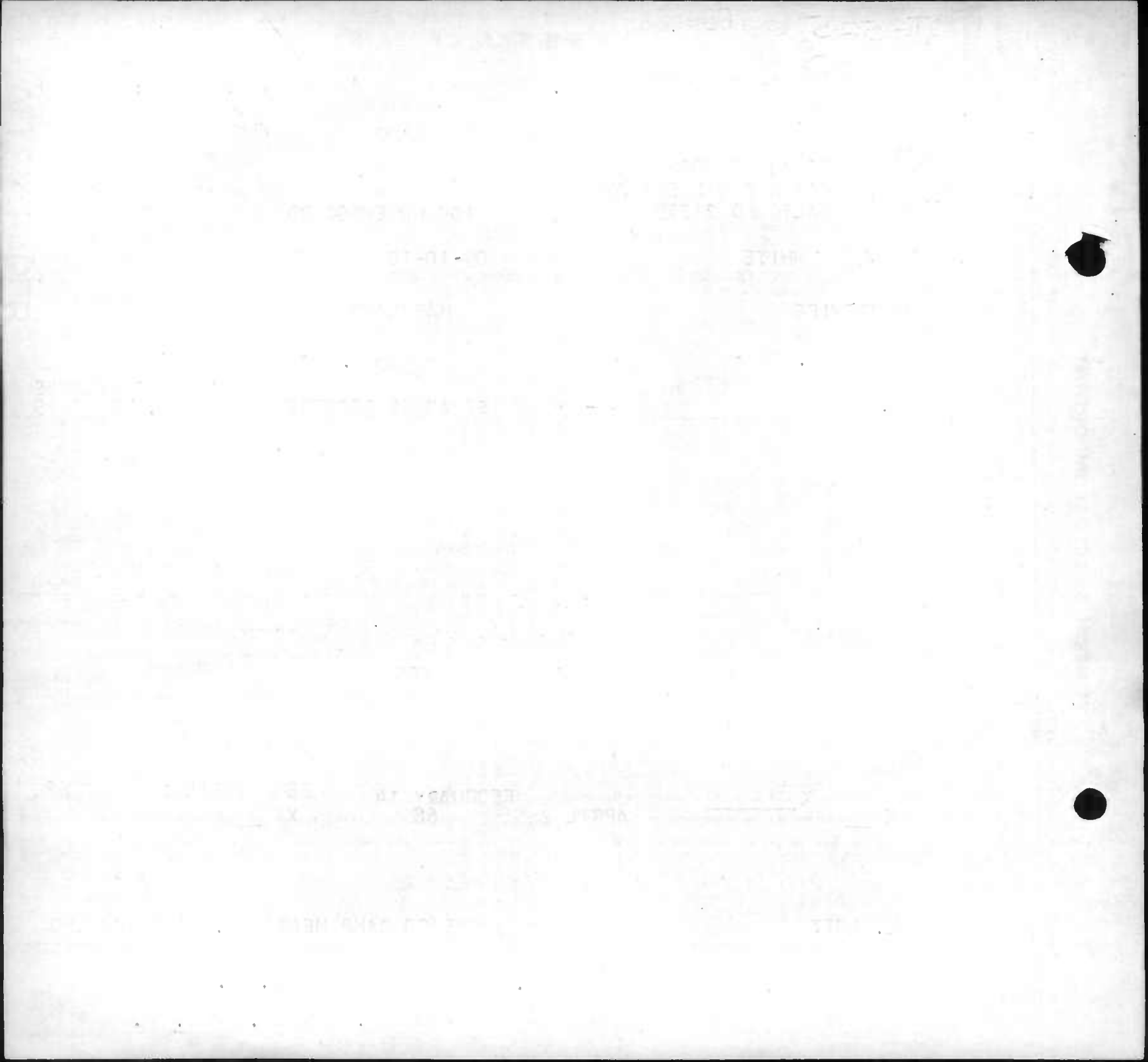
*20e.*

*Step 2 pages*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

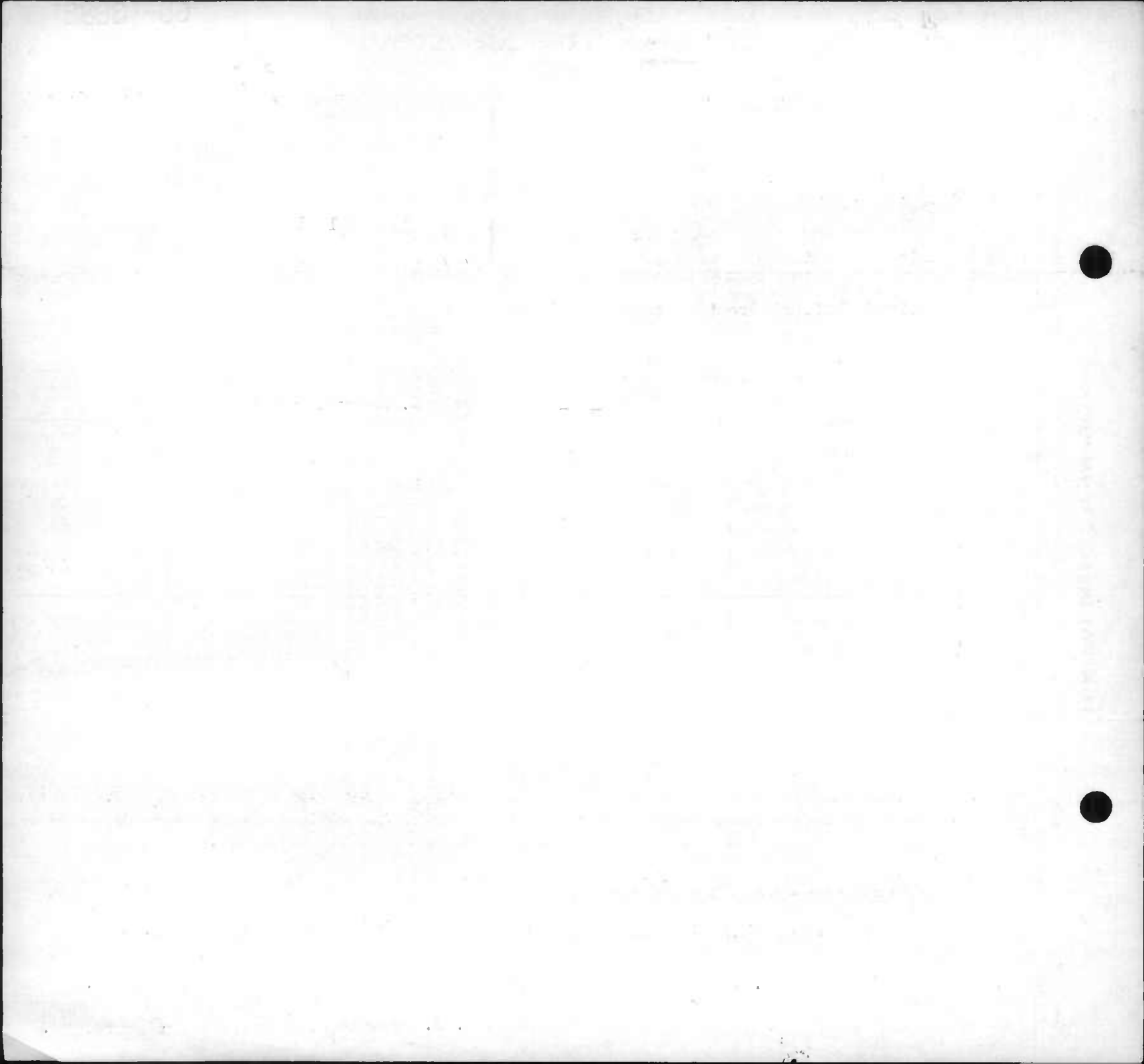
J-525		68-3681		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3681	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNSON, ESTELLE M.</b>				2. DATE AND HOUR OF DEATH <b>APRIL 2, 1968 9:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO MD 21229</b>				C. CITY OR TOWN <b>LINTHICUM</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>105 HOMEWOOD RD</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>09-10-10</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>George W. White</b>				14. MOTHER'S MAIDEN NAME <b>Estelle T. Fuller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-48-8458</b>		17. INFORMANT <b>ST AGNES RECORDS</b>	
ADDRESS <b>CATON &amp; WILKENS BALTO, MD 21229</b>							
18. <b>208X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>RECURRENT PULMONARY EMBOLI</b>				<b>- 1 DAY</b>			
19. <b>294X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>GR. FOR AMPUTATION RIGHT LOWER FOOT</b>				<b>GR. FOR PNEUMONIA CERULEA DOLENS</b>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEBRUARY 14</b> 19 <b>68</b> to <b>APRIL 2</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 2</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Leonard J. Ruck</i> DEGREE						23B. DATE SIGNED <b>4/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>L. LOTT</b>						23D. ADDRESS <b>21090 529 SO CAMP MEADE RD. LINTHICUM, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>						24B. DATE <b>4/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cem.</b>						24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>				25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	
ADDRESS							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

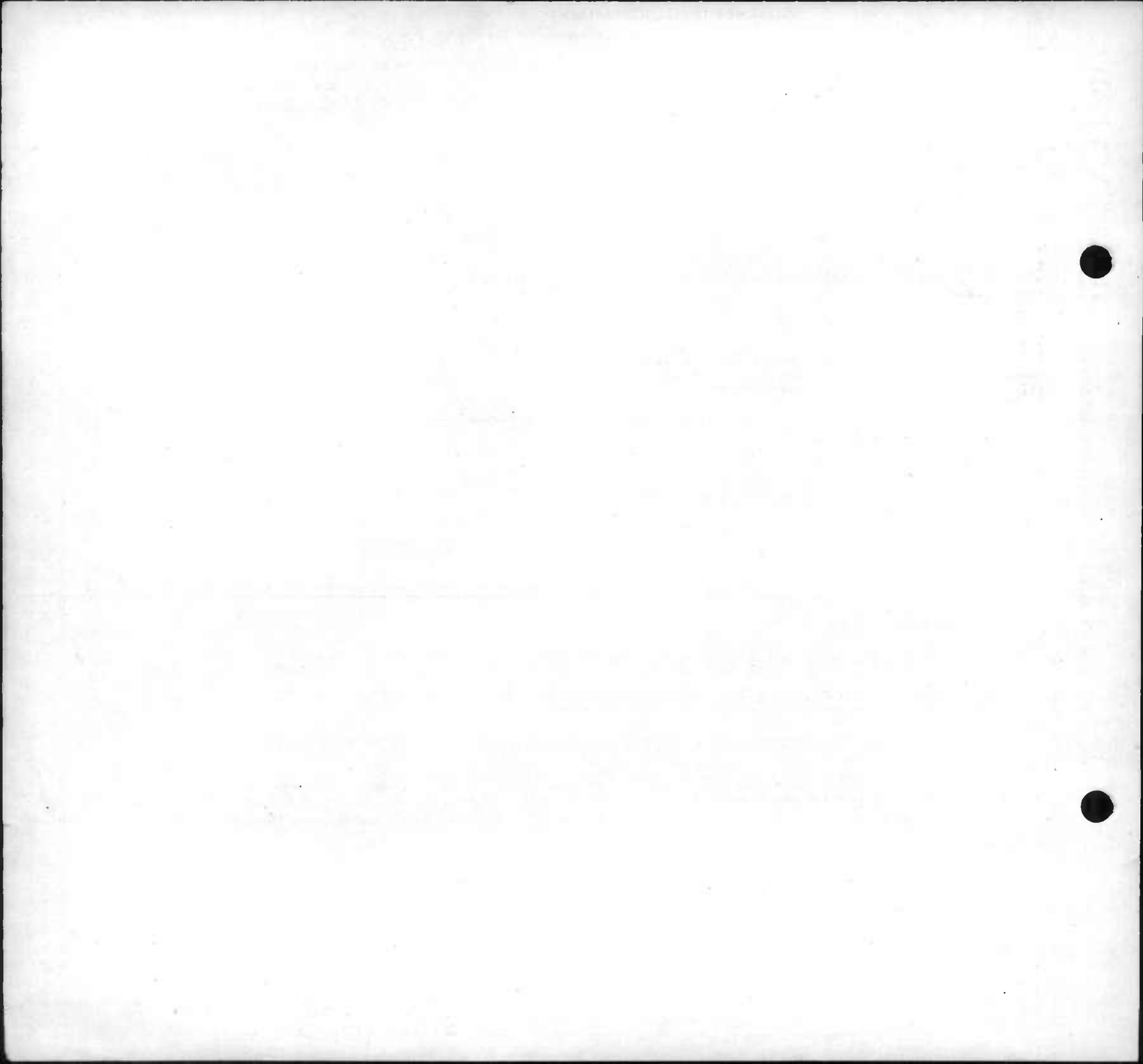
A536		68-3682		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3682	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOHN ROSSER ANDREW			
2. DATE AND HOUR OF DEATH				MARCH 31, 1968 12:30 A.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				13 NATIONAL DRIVE BALTIMORE 53-00			
5. SEX Male				6. RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1/2/1915 52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired National Brewing Company Employee				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME JOHN R. ANDREW				14. MOTHER'S MAIDEN NAME MATTIE POOLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. 216-10-9182			
17. INFORMANT Merle W. Andrew, Baltimore, Maryland				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cerebral Hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 3/31/68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II			
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Mar 29 1968 to Mar 31 1968, that (I) (we) last saw the deceased alive on Mar 31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francisco Baltazar, MD				23B. DATE SIGNED 3/31/68			
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR MD				23D. ADDRESS Church Home & Hosp. Balto 31, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Apr. 3, 1968			
24C. NAME OF CEMETERY OR CREMATORY Concord Cemetery				24D. LOCATION Near Federalsburg, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 4 1968				25B. NAME OF REGISTRAR Robert E. Farber, MA			
25C. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.				ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-3683	
C-462 68-3683					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Clark, Lillian Humphrey</i>		2. DATE AND HOUR OF DEATH <i>4-2-68</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>507 Calhoun St</i>		5. SEX <i>F</i>		6. RACE <i>N</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/14/1894</i>		9. AGE (In years last birthday) <i>74</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212 32 2645</i>		17. INFORMANT <i>Hospital Records</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>CONGESTIVE HEART FAILURE</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>MYOCARDIAL INFARCTION ACUTE</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <i>420.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. DATE OF OPERATION <i>2</i>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-2-68</i> to <i>4-2-68</i> that (I) (we) last saw the deceased alive on <i>4-2-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nak Joony Im</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Nak Joony Im</i>	
23D. ADDRESS <i>Franklin Square Hospital</i>		23E. FUNERAL DIRECTOR <i>Stetson D. Wilson</i>		23F. ADDRESS <i>1913 W. Bal</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/6/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 4 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	



68-3684

## CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Katie Reynolds

2. DATE AND HOUR OF DEATH

4/1/68

3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

2309 Rosalyn Ave. # 21216 007

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

# 21224

BCH: Records 4940 Eastern Ave. Baltimore, Md.

18. 450X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.

CAUSE OF DEATH

IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Probable Pulmonary embolus

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-28-68 19 to 4-1-68 19, that (I) (we) last saw the deceased alive on 4-1-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George Nahra, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

4/1/68

23C. PHYSICIAN'S NAME (Type)

George Nahra Md.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

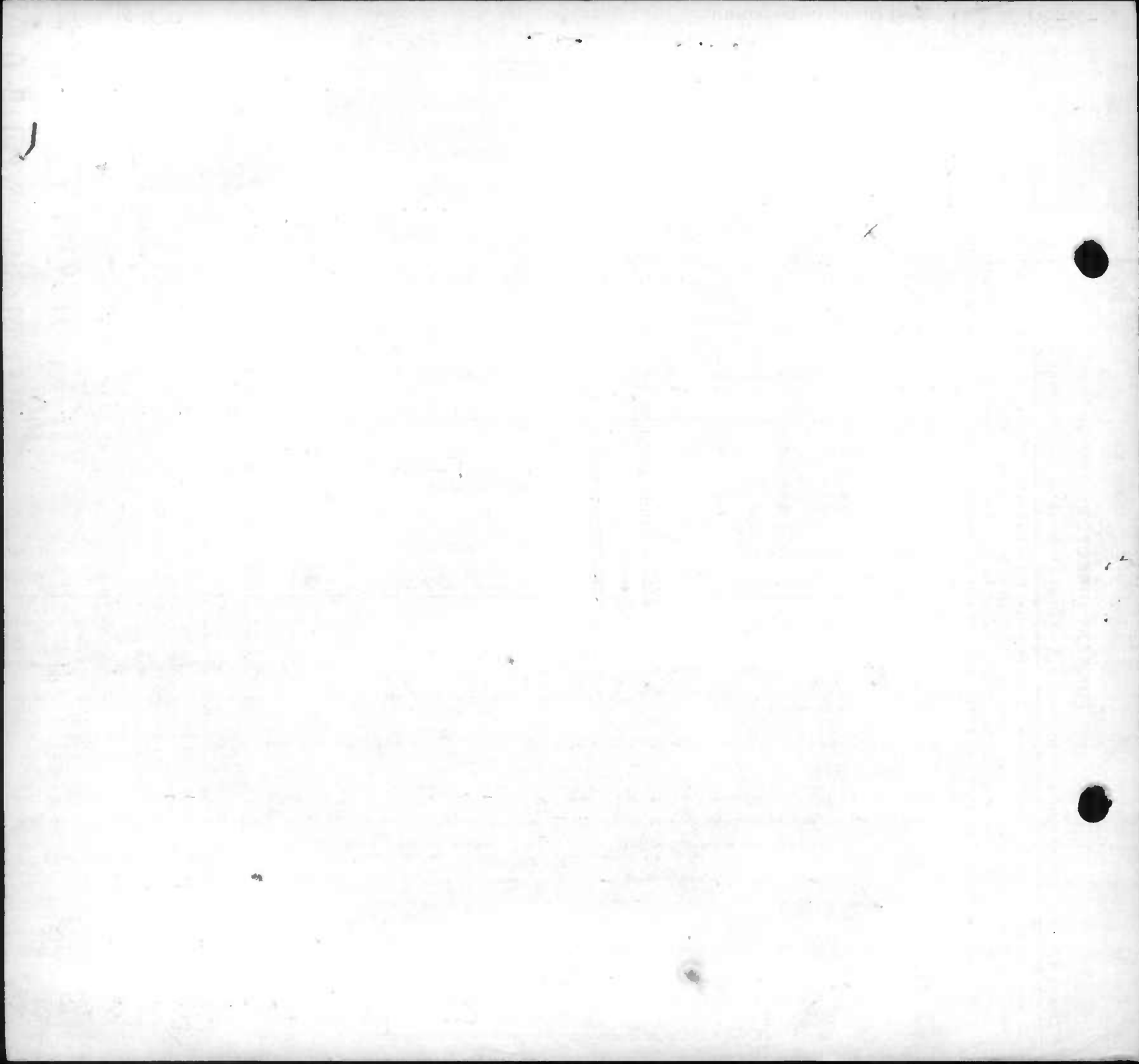
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3

CERTIFICATION APPROVED BY  
 [Signature]  
 DEPT. ASST. MEDICAL EXAMINER

1548

Robert E. Fairbank  
Sitting & v. idem 1313 W. Baltimore City



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				DR. KLUGE		SPS-3685	
BIRTH NO. 68-3685				CERTIFICATE OF DEATH 36-26-85			
1. NAME OF DECEASED (Type or Print) <b>IRA Scott</b>				2. DATE AND HOUR OF DEATH <b>4-2-68 9:50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>806 Ridley Ave</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-26-97</b>		9. AGE (In years last birthday) <b>70</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Scott</b>				14. MOTHER'S MAIDEN NAME <b>Lemonda Sammons</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Maybelle Scott</b> ADDRESS <b>806 Ridley St</b>	
18. <b>4/2/9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Left CVA &amp; old PCVA</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>422.1 II</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Left CVA &amp; old PCVA</b> (C) <b>2 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-1-68</b> to <b>4-2-68</b> , that (I) (we) lost saw the deceased alive on <b>4-2-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>McRae Williams, M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>McRae Williams MD</b>				23D. ADDRESS <b>University of Maryland Hospital, Baltimore, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-7-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Rock Hill</b>		24D. LOCATION (City, town, or county) (State) <b>S.C.</b>	
25A. DATE ISSUED BY HEALTH DEPT. <b>APR 4 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>66 W. Banne St</b>	

and other things

the first of the year

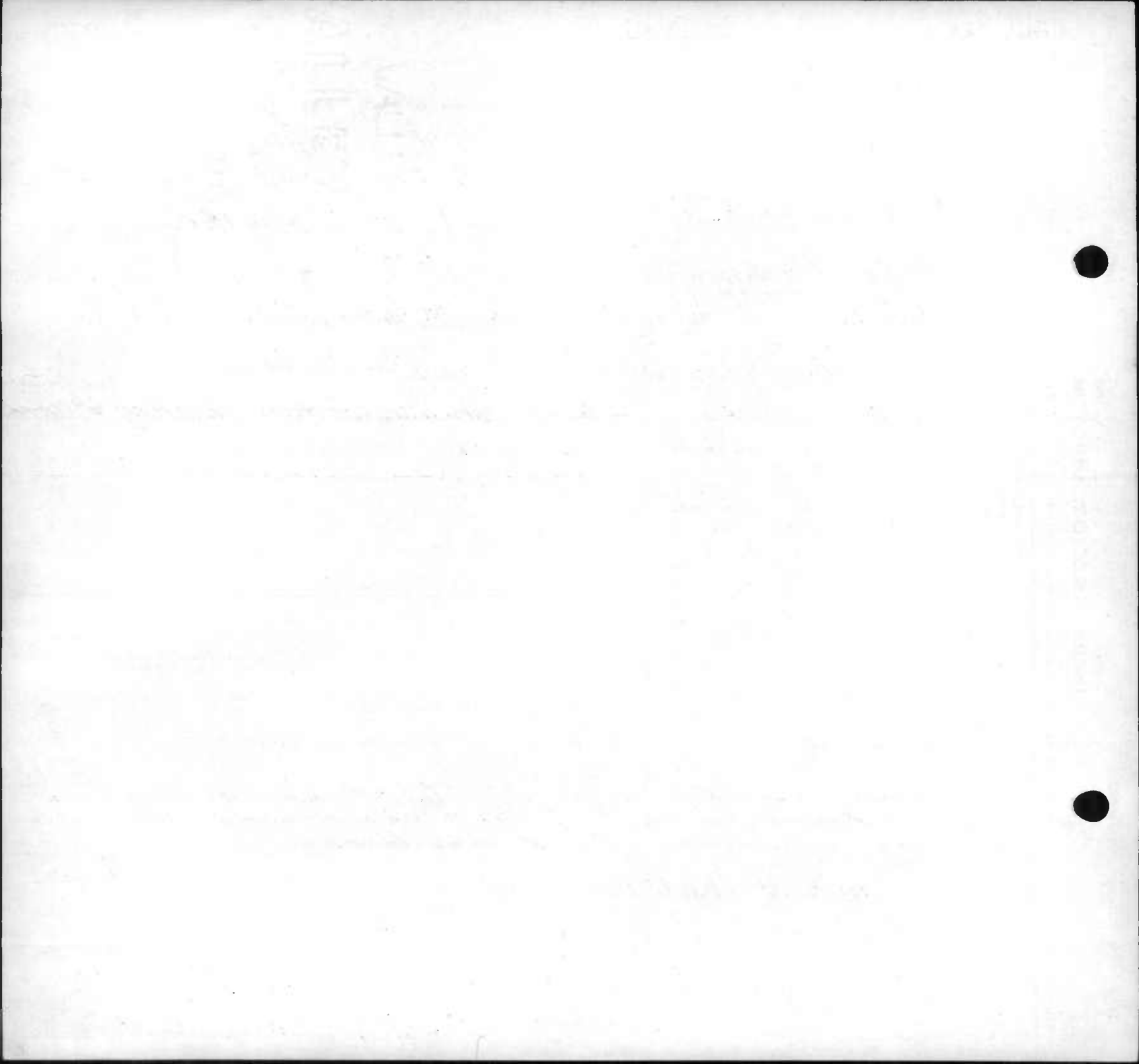
the first of the year

2-1-4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3686		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3686	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>HENRY Mc GARTHY</i>		2. DATE AND HOUR OF DEATH <i>3/30/68 7:55 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore Co</i> C. CITY OR TOWN <i>Baltimore, Md.</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>6917 Parsons Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 6, 1899</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self-employed - Trucks</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>John Timothy McElrath</i>		14. MOTHER'S MAIDEN NAME <i>Frances McGee</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Mary Catherine McElrath</i>	
18. <i>+92X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>PULMONARY EMPHYSEMA</i> (A) IMMEDIATE CAUSE <i>COR. PULMONALI</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 YEARS</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>527.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/1963</i> to <i>3/30 1968</i> , that (I) (we) lost saw the deceased alive on <i>3/30 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph C. Matchar MD</i>				23B. DATE SIGNED <i>3/30/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH C. MATCHAR MD</i>		23D. ADDRESS <i>6822 REGISTERSTOWN RD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 2, 1968</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Trinity Ridge Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville 8, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>	
25C. FUNERAL DIRECTOR <i>Frank A. Jewell</i>		25D. ADDRESS <i>Pikesville 8, Md.</i>			



1  
5-330

68- 3687

BALTIMORE CITY HEALTH DEPARTMENT

68- 3687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 68-02666

1. NAME OF DECEASED (Type or Print) <b>TAVIA STITH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>April 2, 1968</b> <b>8:55 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>X2 1515 W. North Avenue (Sinai Clinic)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 2, 1968</b> <b>8:55 A.M.</b>	
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY
9. DATE OF BIRTH <b>Feb 9 - 1968</b>		10. AGE (In years lost birthday) <b>7 yrs 1 mo 21</b>	C. CITY OR TOWN <b>Baltimore</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	E. STREET AND NUMBER <b>1924 N. Fulton Ave</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	15. MOTHER'S MAIDEN NAME <b>Wleborch Keys</b>
18. INFORMANT <b>Gladys Key</b>		ADDRESS <b>1924 N. Fulton Ave</b>	

19. <b>484 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH <b>Interstitial Pneumonitis (SDII)</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II <b>525 X</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		

20A. DATE OF OPERATION <b>2</b>	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Werner U. Spitz, M.D.** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) **Werner U. Spitz, M.D.** ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **4/2/68**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 6/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mt. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 4 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	25C. FUNERAL DIRECTOR <b>J. Brooke Piggold</b>	ADDRESS <b>1463 N. Carroll St</b>

Feb 7-1968 York  
Baltimore Md

1964 W. Virginia Car  
Travelled 27.4h  
Black Trip  
Sleeping July 1964 W. Va.

General Capital & Christmas Market Balto  
J. Buckle Supply 1964

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

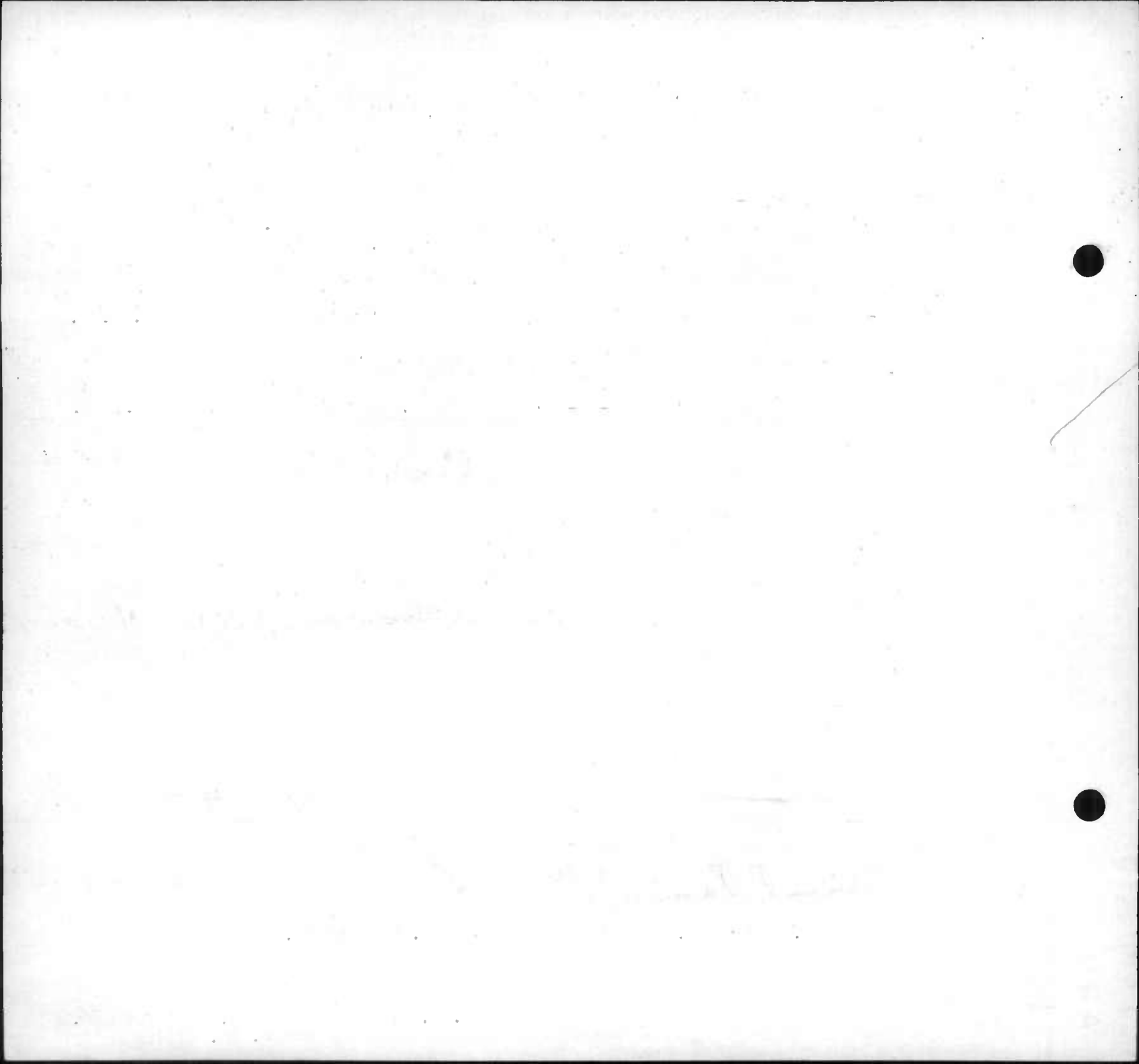
68- 3688

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 3688

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Thomas S. Hutcheson		April 1, 1968 7:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  House in Pines - Belvedere				A. STATE Maryland	
				B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3304 Fairview Ave.	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/12/1889	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Partner		10B. KIND OF BUSINESS OR INDUSTRY Metal Products		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Hutcheson				14. MOTHER'S MAIDEN NAME Emma Royston	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-34-3580		17. INFORMANT John R. McGreevy	
				ADDRESS Balto., Md.	
18. <u>433.7</u> I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral thrombosis, right</u>			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Cerebral thrombosis, left</u>			
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>1964</u> to <u>4-1</u> 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>3-30</u> 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <u>William P. Benson, Jr.</u> M.D. DEGREE				23B. DATE SIGNED 4-2-68	
23C. PHYSICIAN'S NAME (Type) Dr. William P. Benson				23D. ADDRESS 3506 N. Calvert St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/68		24C. NAME OF CEMETERY or CREMATORY Jessops	
24D. LOCATION Baltimore County,		24E. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 4 1968		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. Md. 21212	



51-44-65 1B

68-3689

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-3689

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

BAINES

THEODORE H.

2. DATE AND HOUR OF DEATH

4/3/68

2:30

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 BALTO. CITY HOSPITALS  
4940 EASTERN AVENUE  
BALTIMORE, MD. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE 653-00

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

624 CARVEL GROVE RD.

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-8-08

9. AGE (In years  
last birthday)

60

If Under 1 Yr.

If Under 24 Hrs.

Months Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CONSTRUCTION

10B. KIND OF BUSINESS OR INDUSTRY

SELF EMPLOYED.

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Howard BAIN

14. MOTHER'S MAIDEN NAME

Mary Garner GARNETT M. McCULLOR

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

-

16. SOCIAL  
SECURITY NO.

17. INFORMANT

21224 ADDRESS

RECORDS-4940 EASTERN AVENUE, BALTIMORE, MD

18. 151-9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

METASTATIC NEOPLASIA

of stomach - spread (to liver-lungs)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

ASCVA - CHF - (DIGITOXICITY)

7 years

(C)

151X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from  
thot (I) (we) last saw the deceased alive on 4/3/68

4/2/68

19 68

4/3

19 68

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G. ARCON

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

4/5/68

23C. PHYSICIAN'S  
NAME (Type)

GRACIEA S. ARCON

DEGREE

23D. ADDRESS

BCH-4940 EASTERN AVENUE, BALTIMORE, MD 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-6-68

24C. NAME OF CEMETERY OR CREMATORY

GARDENS OF FAITH Cem.

24D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Stanley Miller - 2334

ADDRESS

Jefferson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

80

CO N/3

~~1/3~~ 1/3

1/3

1/3

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3690</u>	
<div style="display: flex; justify-content: space-between;"> <span>5-200</span> <span>68-3690</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <u>MARY (MAMIE) B. SCHRECH</u>			2. DATE AND HOUR OF DEATH <u>4-4-68</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>5029 E. PRESTON ST.</u>			A. STATE <u>MARYLAND</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>			6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		8. DATE OF BIRTH <u>5-14-1875</u>
13. FATHER'S NAME <u>BEVERLY W. SUNDERLAND</u>			14. MOTHER'S MAIDEN NAME <u>SALLY ESPEY</u>		9. AGE (In years last birthday) <u>92</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates at service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
17. INFORMANT <u>Mrs. Mary Allen - 5029 E. Preston St.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
18. <u>402X I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Chronic Arteriosclerosis Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:		
443X II			(C) <u>Toxic Necrotic</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1960</u> to <u>April 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 1, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William Geyer</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>WM. G. GEYER</u>				23D. ADDRESS <u>156 H. Milton Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-8-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Heather Miller</u>		25D. ADDRESS <u>2334 Jefferson St.</u>	

TO: HONORABLE J. P. ROSS

AT: WASHINGTON, D. C.

RE: [illegible]

DATE: [illegible]

BY: [illegible]

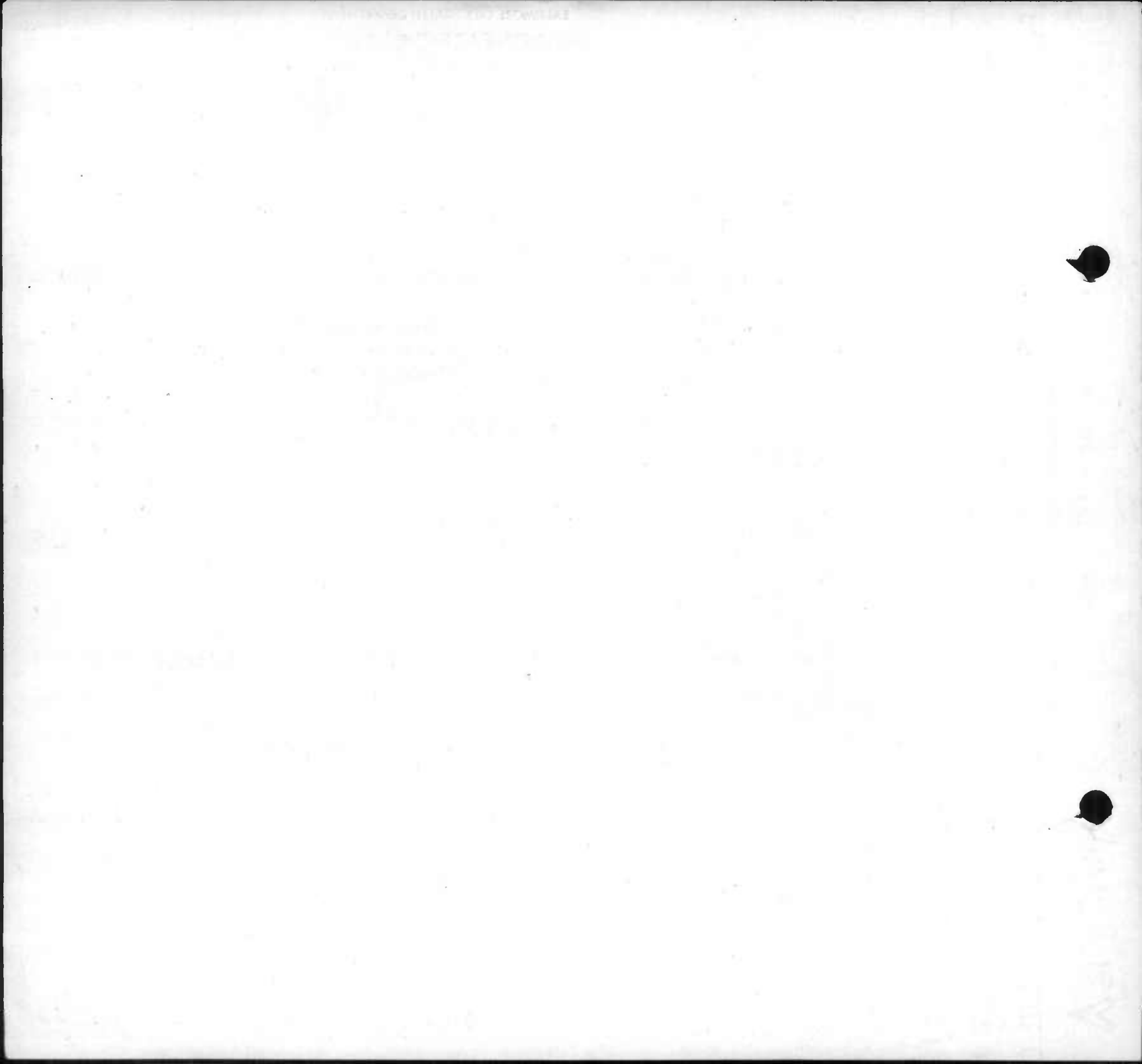
Very truly yours,

Jefferson - 4334

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-000		68-3691		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3691	
1. NAME OF DECEASED (Type or Print) <b>DAY, Agnes</b>				2. DATE AND HOUR OF DEATH <b>4-2-68 6:45am</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED O.E.O.  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>G.A.C.</b> C. CITY OR TOWN <b>Severn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 172 - Fort Meade Rd</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-9-1888</b>	9. AGE (In years last birthday) <b>80 approx</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James H. Marshall</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Queen</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Louise Marshall - Severn Rd</b>		ADDRESS	
18. <b>395.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>cardiac arrhythmia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>aortic stenosis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>cardiac arrhythmia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>aortic stenosis</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1d</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>421.1 II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-1-68</b> 19 to <b>4-2-68</b> 19, that (I) (we) last saw the deceased alive on <b>7:10 AM</b> 19 <b>4-2-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>V.J. Felitti MD</b>				23B. DATE SIGNED <b>4-2-68</b>		23C. PHYSICIAN'S NAME (Type) <b>V.J. Felitti MD</b>	
23D. ADDRESS <b>University Hospital</b>		23E. ADDRESS <b>University Hospital</b>		23F. ADDRESS <b>University Hospital</b>		23G. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>4/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St Rose</b>		24D. LOCATION (City, town, or county) (State) <b>Harmon Rd</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Marshall P. Hughes</b>		25D. ADDRESS <b>638 N. Gilman St</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

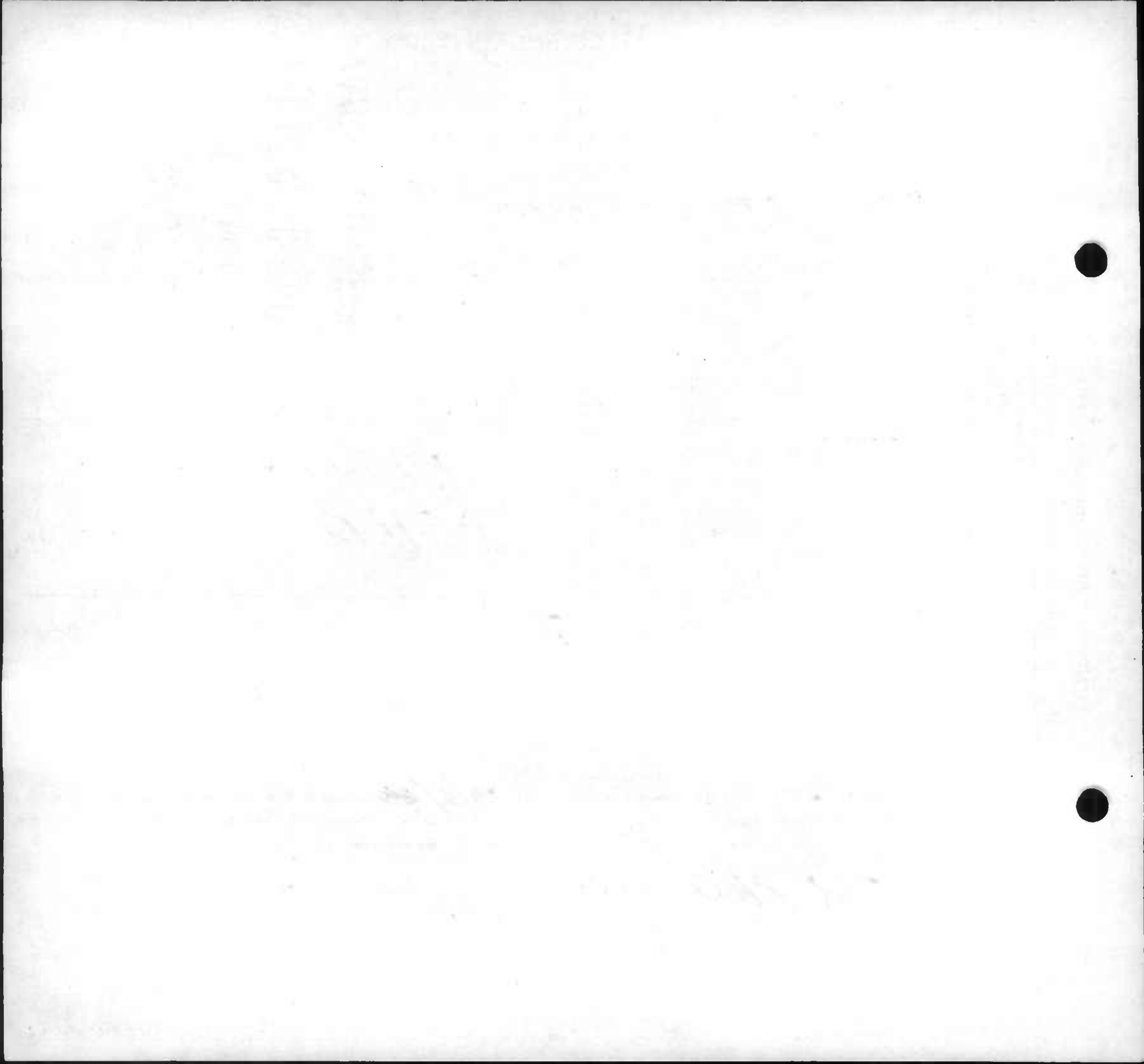
68- 3692

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3692

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LAURA BIRD</b>		2. DATE AND HOUR OF DEATH <b>4/3/68 10:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTIMORE</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY NUMBER? <b>14-03</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2311 ETTING STREET</b>	
5. SEX <b>Female</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-09</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE BROOKS</b>		14. MOTHER'S MAIDEN NAME <b>LUCY POTTER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-32-4006</b>		17. INFORMANT <b>Collene Brooks</b> ADDRESS <b>SAME</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASHD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>many years</b>	
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>CK/A.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/6/68</b> 19 <b>68</b> to <b>4/3</b> 19 <b>68</b> , that (H) (we) last saw the deceased alive on <b>4/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Kelson M.D.</b> DEGREE				23B. DATE SIGNED <b>4/3/68</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pr.</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>		25A. DATE RECD. BY HEALTH DEPT. <b>APR 5 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fairburne</b>		25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b> ADDRESS <b>1348 Calhoun St.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3693

BIRTH NO.

REG. NO.

1. NAME OF DECEASED  
(Type or Print)

CARL FANNIN

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

Franklin Square Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 3, 1968

6:00 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11-9-1924

10. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1300 Hollins Street

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Homer Fannin

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Lab. Tech

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elizabeth Fannin

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

M.M. 2

17. SOCIAL  
SECURITY NO.

401-22-0035

18. INFORMANT

ADDRESS

Mrs. Lillian Cooper Perry

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cerebrocranial injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1300 Hollins Street

22D. TIME  
OF INJURY  
(APPROX.)

4-1-68

10:10 P.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Undetermined Fell down stairs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☒ACTUAL  
SIGNATURE

Charles S. Springate

M.D.

EXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 4, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/6/68

24C. NAME of CEMETERY or CREMATORY

Baltimore Mt. Carmel

24D. LOCATION (City, town, or county)

Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

Thos. J. Henney Inc. Hollins St.

ADDRESS

1660

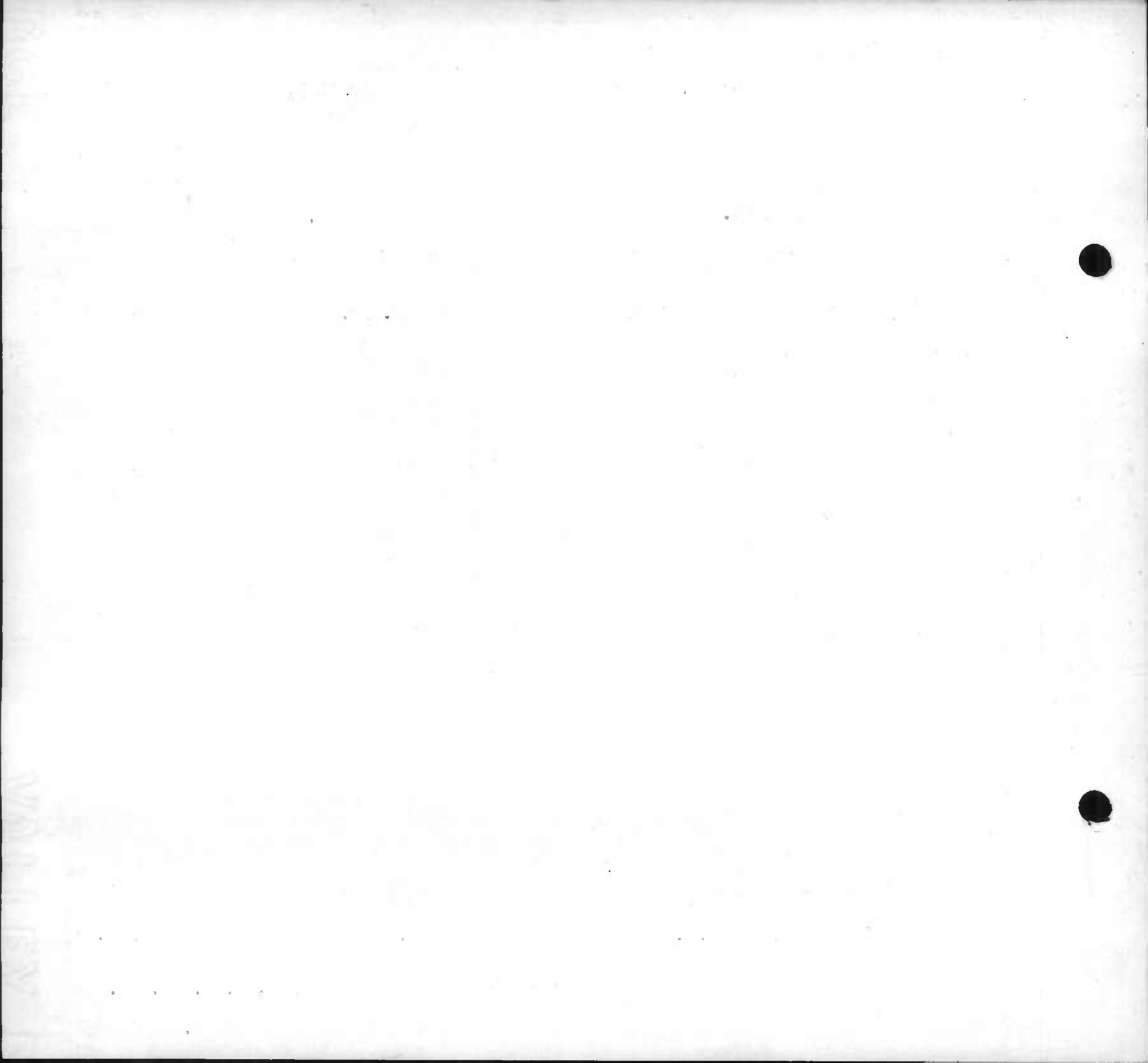
APR 5 1968

4/15/68 - Marriage record - #03941 - CARL FANNIN  
and MART E. NALLY. Dm. 11/15/1952.  
Bapt. Ch. JFC.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68- 3694</u>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>Rosa C. Ellerman</u>			<u>April 3, 1968</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <u>00</u> <u>1811 Light St.</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>
			E. STREET AND NUMBER <u>1811 Light St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 6 1884</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Louis Murphy</u>			14. MOTHER'S MAIDEN NAME <u>Mary Morningrose</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Family</u>		ADDRESS <u>Same</u>
18. <u>4/12/9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>420.0</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic cholelithiasis</u>			CAUSE OF DEATH  (A) IMMEDIATE CAUSE <u>disease</u> <u>Arterio sclerotic heart</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About 7-8 yrs</u> <u>About 9 yrs</u> <u>About 10 yrs</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>10/6/52</u> 19 to <u>4/3/68</u> 19, that (I) (we) last saw the deceased alive on <u>4/1/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry Deibel M.D.</u>				23B. DATE SIGNED <u>April 4, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry Deibel M.D.</u>		23D. ADDRESS <u>1226S. Hanover Street Balto. Md. 21230</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4 6 68</u>	24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>	24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>	25C. FUNERAL DIRECTOR <u>Mc Cully</u>		ADDRESS <u>130 E. Fort Ave</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

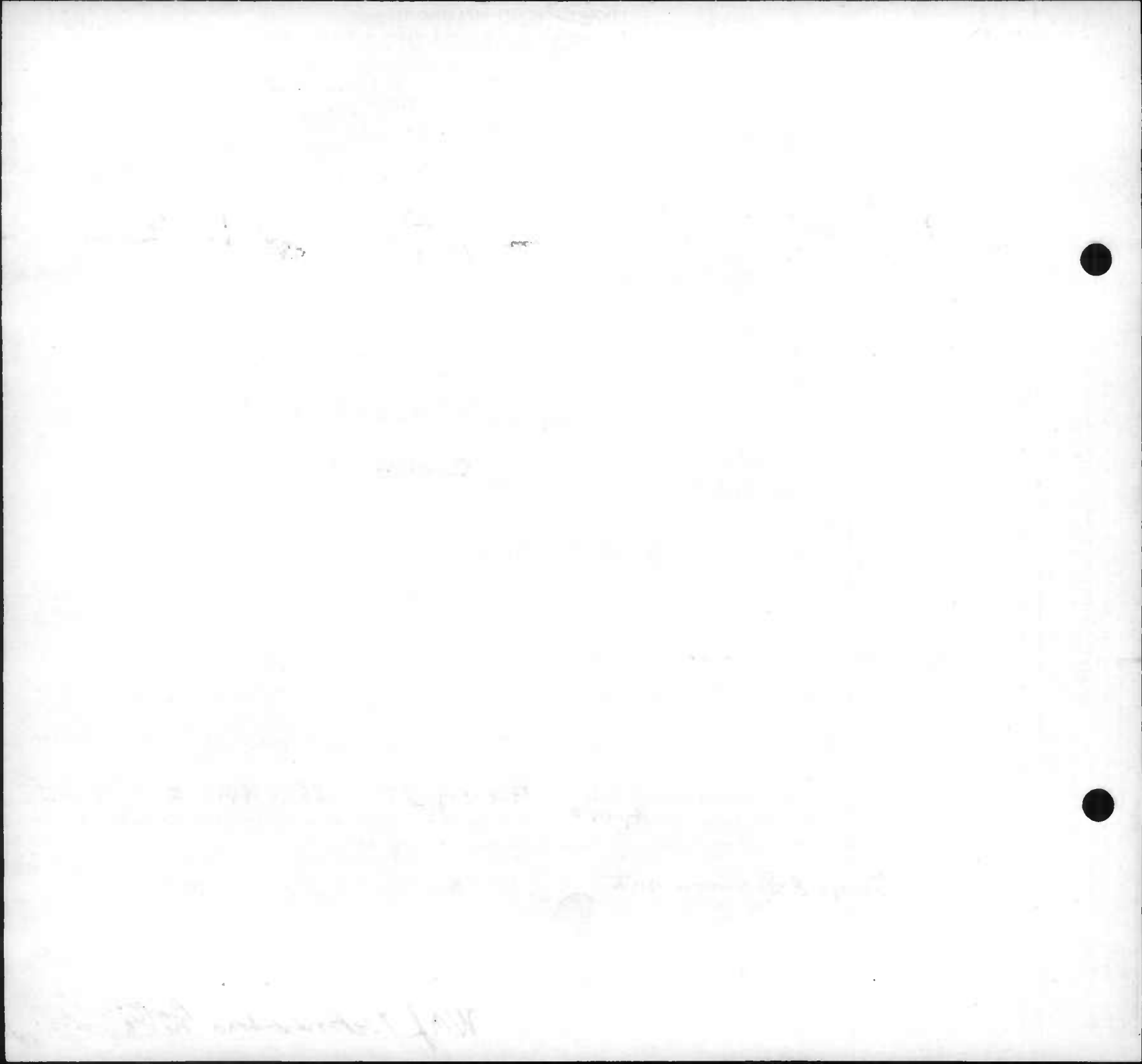
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3695</u>
BIRTH NO. <u>68-3695</u>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>John Marks</b>		2. DATE AND HOUR OF DEATH <b>3/26/68</b> <span style="float: right;"><b>500 P.M.</b></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Lincoln Nursing Home</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> E. STREET AND NUMBER <b>2502 E. Lincoln Avenue</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1901</b>	9. AGE in years <b>67</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNK.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNK.</b>		11. BIRTHPLACE (State or foreign country) <b>Mich.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNK.</b>		
14. MOTHER'S MAIDEN NAME <b>UNK.</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>John Marks</b>		
18. <b>162.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOGENIC CARCINOMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <b>162.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7-27-67</b> to <b>3-26-68</b> and that (I) (we) last saw the deceased alive on <b>3-26-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>3-26-68</b>
23C. PHYSICIAN'S NAME (Type) <b>HOAGUE JENNABINE</b>				23D. ADDRESS <b>5519, Kennison Avenue Baltimore Maryland</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/29/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lindbergh Park Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>3800 Fred Ave.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>		25C. FUNERAL DIRECTOR ADDRESS <b>T. Kishel - 1930 Eastern Ave</b>		

Wm. L. Davis  
Thos. Franklin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-3696</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">68-3696</span></span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <b>Maud Hissey</b>			2. DATE AND HOUR OF DEATH <b>April 2, 1968</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>614 North Hilton Street Baltimore, Md. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> E. STREET AND NUMBER <b>614 North Hilton St. 29</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/1884</b>	9. AGE (In years lost birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wm. Hissey</b>			14. MOTHER'S MAIDEN NAME <b>Laura Glanding</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss Katherine Knipp same address</b>	
18. <span style="font-size: 1.5em;">782.4</span> I <span style="font-size: 1.5em;">I</span> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Failure.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
19. <span style="font-size: 1.5em;">782.4</span> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 28 1968</b> to <b>April 2 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 2 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George E. Shannon M.D.</b>				23B. DATE SIGNED <b>April 3, 1968</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 6 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. F. Johnson &amp; Sons Baltimore, Md.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)  
GEORGEF. SHRADER ~~KKKKK~~

2. DATE

Known ☐ Estimated ☒

Month

Day

Year

Hour

OF  
DEATH

March 30, 1968

7:50 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3038 Chesterfield Avenue

3. DATE  
PRONOUNCED DEAD

March 31, 1968

6:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

6. SEX

male

7. RACE

white

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

JULY 4, 1905

10. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3038 Chesterfield Avenue

11. BIRTHPLACE (State or foreign country)

WAYNESBORO, PA.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

ELMER SHRADER

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

STEAM FITTER UNION LOCAL 438

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

SARAH A. BAKER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

MRS. G. F. SHRADER 3038 CHESTERFIELD

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Overdose of Barbiturates

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

3038 Chesterfield Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY bet. 3/31/68 8:30 P.M.  
(APPROX.) Bet. 7:50 P.M. - 7:50 P.M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

ingested an overdose of barbiturates

23. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4/4/68

24C. NAME OF CEMETERY or CREMATORY

CATHEDRAL

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

H.W. MEARS &amp; SON 805 N. CALVERT ST.

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3698

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 3698

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Leo G. Houck</u>		2. DATE AND HOUR OF DEATH <u>April 3, 1968</u> <u>11 25</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>4-10-68</u> <u>426 E. 28th Street</u> <u>Baltimore, Md. 21218</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>13016 Md 21218</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>13 May 1927</u>		9. AGE (In years lost birthday) <u>40</u>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trailer Dispatcher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles W. Houck</u>		14. MOTHER'S MAIDEN NAME <u>Agnes E. Trainor</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>War 11</u>		16. SOCIAL SECURITY NO. <u>219-22-1654</u>		17. INFORMANT <u>Houck</u> <u>Mary Jane Houck (Wife)</u> Same	
18. <u>1621</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>163X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Carcinoma of lung left</u> <u>6-8 months</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> to <u>Apr 3</u> 19 <u>68</u> , that (I) (we) <del>last saw</del> the deceased alive on <u>Jan 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore J. Graziano MD</u>		23B. DATE SIGNED <u>Apr 3, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>Theodore J. Graziano MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>		25D. ADDRESS <u>5209 York Road</u> <u>Seitz Funeral Home Balto. Md. 21212</u>		25E. ADDRESS	

V.S. 153

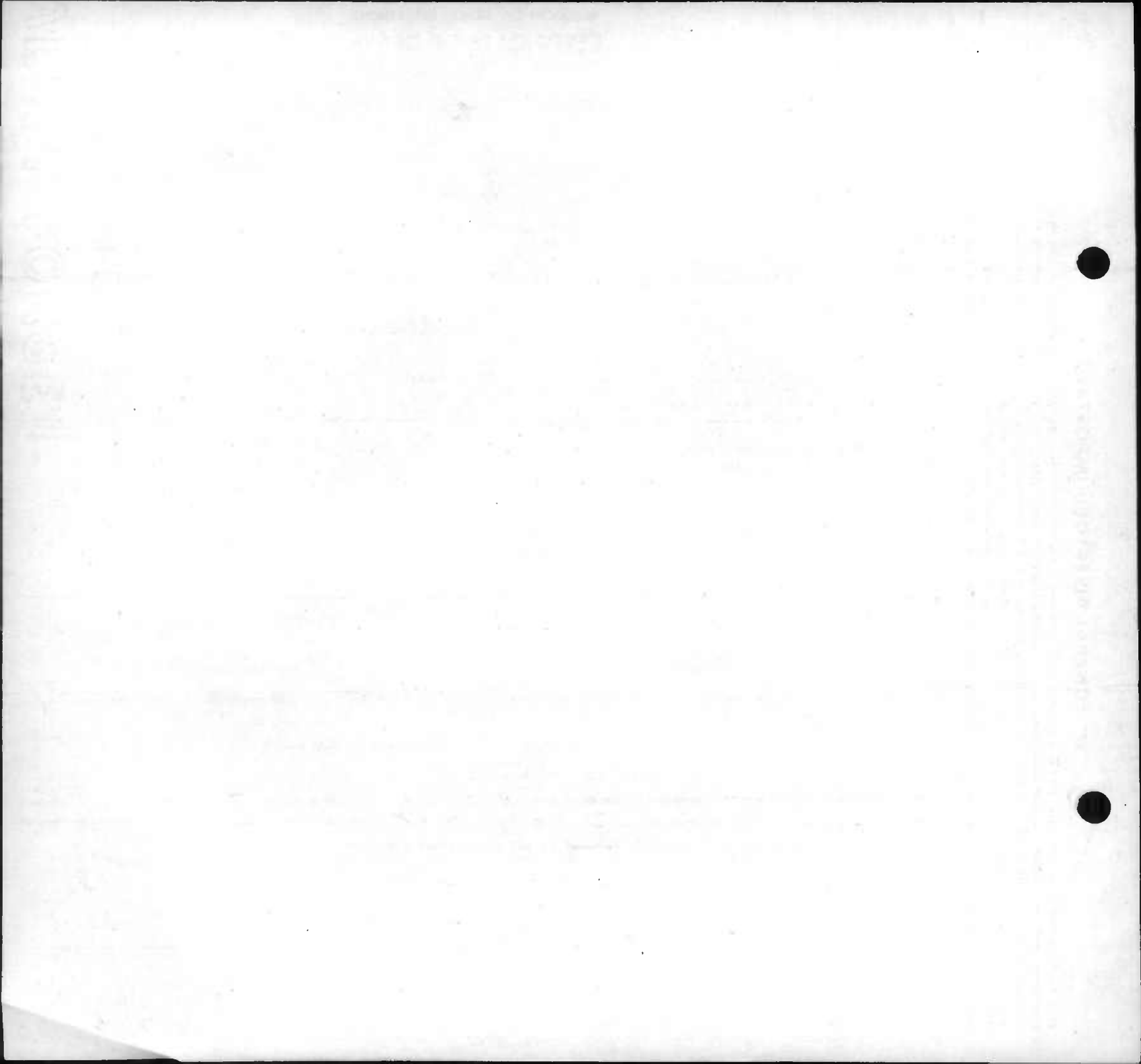
4-10-68

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 3699</span>	
68- 3699				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">GEORGE W. EISENHARDT</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">4/3/1968</span> <span style="float: right;">3<sup>15</sup> P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.1em;">MD.</span> B. COUNTY <span style="font-size: 1.1em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">1161 SARGEANT ST.</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <span style="font-size: 1.1em;">1161 SARGEANT ST. (21223)</span>	
5. SEX <span style="font-size: 1.1em;">M</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">5/15/1915</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">52</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">MESSENGER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">W.BAL. T.V.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">MD.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.1em;">GEORGE EISENHARDT</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">GERTRUDE V. CARLE</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">Yes W.W.II</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">219-09-4095</span>		17. INFORMANT <span style="font-size: 1.1em;">GEORGE M. EISENHARDT</span>	
18. <span style="font-size: 1.1em;">412.941250.9</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.1em;">Acute Pulmonary Edema</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">Old myocardial infarction</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">3 years.</span>	
19. <span style="font-size: 1.1em;">420.1 II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.1em;">Diabetes Mellitus</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">3 years.</span>	
20A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">11 - 25</span> 19 <span style="font-size: 1.1em;">67</span> to <span style="font-size: 1.1em;">4 - 4</span> 19 <span style="font-size: 1.1em;">68</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">2 - 6</span> 19 <span style="font-size: 1.1em;">68</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">Leon Ashman M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.1em;">4-4-68</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">LEON ASHMAN</span>				23D. ADDRESS <span style="font-size: 1.1em;">5907 Guyton Oak Ave 21207</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">BURIAL</span>		24B. DATE <span style="font-size: 1.1em;">4/6/1968</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">LOUDON PARK CEM.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">BALTIMORE, MD.</span>		25A. DATE REGD. BY HEALTH DEPT. <span style="font-size: 1.1em;">APR 5 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Taylor</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">John J. Cowan - Son Inc. 901 Hopkins St. Balt. Md. 21223</span>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-3700  
BIRTH NO. 68-3700  
REG. NO. 68-3700  
BALTIMORE CITY HEALTH DEPARTMENT  
BALTIMORE CITY HEALTH DEPARTMENT  
BALTIMORE CITY HEALTH DEPARTMENT

1. NAME OF DECEASED (Type or Print)		KATE AYRE		2. DATE AND HOUR OF DEATH April 3, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt. Sinai Nursing Home				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3204 Belvedere Ave.			
5. SEX F.	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1880	9. AGE (In years last birthday) 87 Yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George Harman				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-3783		17. INFORMANT John H. Ayre, 3509 Belvedere Ave 21215			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) Cerebral arteriosclerotic (C) Generalized arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks Several years Several years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE OF DEATH March 1, 1968 to April 3, 1968		21H. DATE OF DEATH April 3, 1968	
22. I certify that (I) (the hospital) attended the deceased from March 1, 1968 to April 3, 1968, that (I) (we) last saw the deceased alive on April 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Seymour H. Rubinfeld				23B. DATE SIGNED 4/4/68		23C. PHYSICIAN'S NAME (Type) Seymour H. Rubinfeld	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-68		24C. NAME OF CEMETERY OR CREMATORY Saters Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1968		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		25D. ADDRESS Towson, Md. 21204	

Central Theatre

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Central Theatre

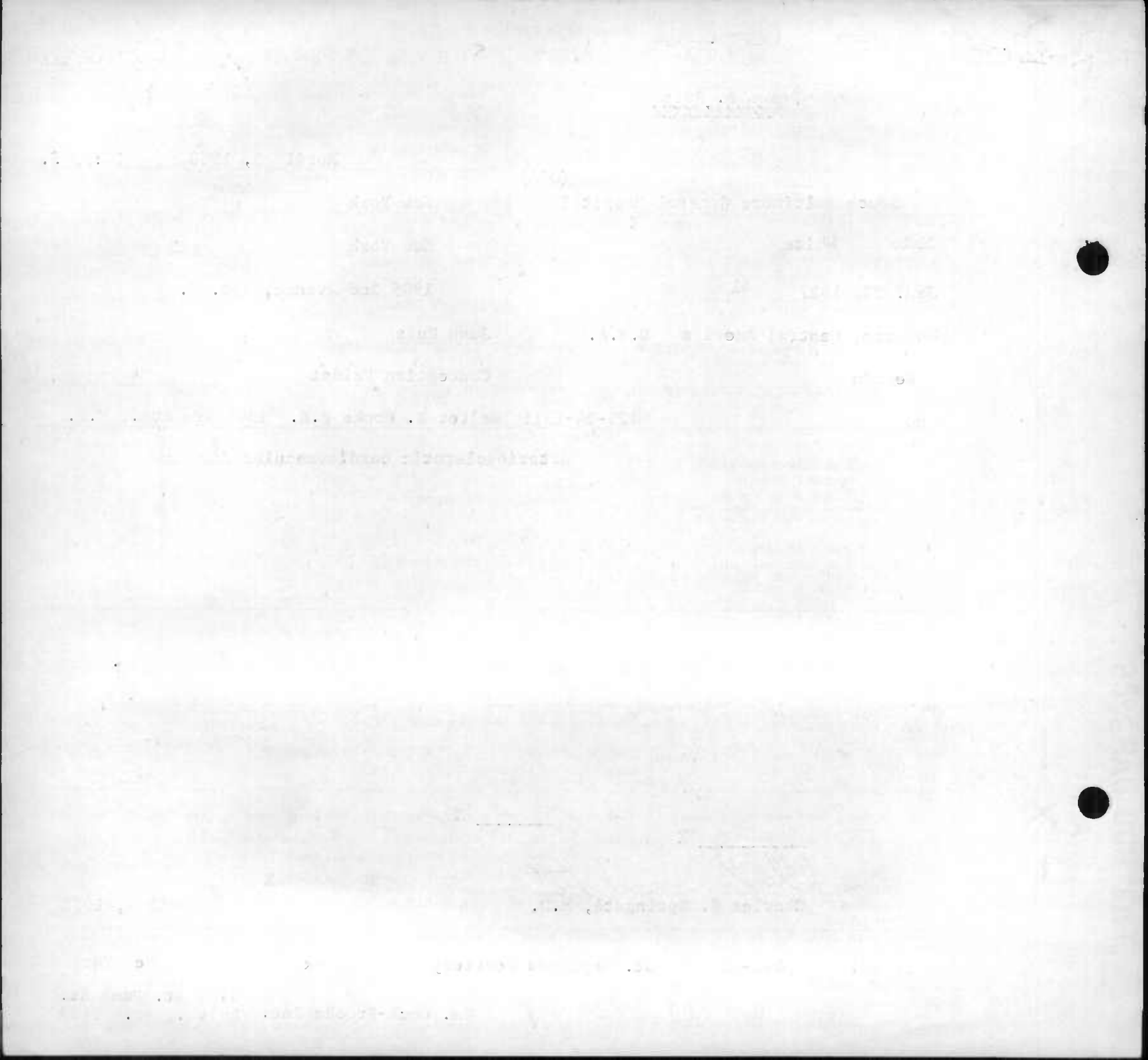
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3701

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Ramon A. Ruiz</b> <del>RAYMOND RUIZ</del>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 3, 1968 10:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b> (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 3, 1968 10:55 P.M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>New York</b> B. COUNTY <b>V-29</b>	
9. DATE OF BIRTH <b>Jan. 23, 1927</b>		10. AGE (In years lost birthday) <b>41</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Honduras, Central America</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>125-24-1511</b>	
18. INFORMANT <b>Walter B. Cooke F.H.</b>		ADDRESS <b>1504 3rd Ave., N.Y.</b>	
19. <b>4/2/91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-2-2-1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 4, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-8-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Raymonds Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Bronx New York</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburne</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc.</b>		ADDRESS <b>1217 St. Paul St. Balto., Md. 21202</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 3702		REG. NO. 68- 3702	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ROBINSON, BERTIE M.</b>				2. DATE AND HOUR OF DEATH <b>04-03-68</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-04</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>				6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>08-12-27</b>		9. AGE (In years last birthday) <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>WILLIAM DAVIS</b>			
14. MOTHER'S MAIDEN NAME <b>MAMIE ROBINSON</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Catharine Payne</b>				ADDRESS			
18. <b>16221</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Acute Cerebral Edema</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Metastatic <del>carcinoma</del> of lung.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Exploratory Craniotomy</b>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>3 4/11/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Mass Lesion</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>68</b> to <b>4/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. F. Brooker Jr. MD.</b>				23B. DATE SIGNED <b>4/3/68</b>		23C. PHYSICIAN'S NAME (Type) <b>A. F. Brooker Jr. MD.</b>	
23D. ADDRESS <b>Johns Hopkins Hospital</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>4-6-68</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Airy Cmt.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 5 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, MA</b>		25C. FUNERAL DIRECTOR <b>Eloy Wilson and Company, Inc.</b>	

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A-536

68- 3703

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3703

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM M. ANDERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>March 31, 1968</b> Hour <b>11:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>211 North Parrish Street</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>March 31, 1968</b> Hour <b>11:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>68</b>		10. AGE (In years lost birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>		15. MOTHER'S MAIDEN NAME <b>?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MIS CHRISTINE ANDERSON,</b>		ADDRESS <b>2440 Druid Hill</b>	
19. CAUSE OF DEATH <b>09391</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Aortic Insufficiency Due To Luetic</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Aortitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>022 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>M Dalvary Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>A Halstead</b>		ADDRESS <b>206 W North Ave</b>	

WALTER B. GORE

W. B. Gore

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3704

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOROTHY WALLACE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>March 31, 1968</b>		Hour <b>4:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>512 West Franklin Street</b>		3. DATE PRONOUNCED DEAD <b>March 31, 1968</b>		Hour <b>10:05 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>11-03</b>			
6. SEX <b>female</b>		7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH <b>11/7/29</b>		10. AGE (In years last birthday) <b>37</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF <b>U.S.</b>		13. FATHER'S NAME <b>John Mott</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>	
15. MOTHER'S MAIDEN NAME <b>Betty Martin</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MRs Betty Logan,</b>		ADDRESS			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Death During Epileptic Seizure</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>3-3-3</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spetz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spetz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/1/68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME of CEMETERY or CREMATORY <b>M<sup>r</sup> Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			
25D. ADDRESS <b>1206 W North Ave</b>					

VALLEY PAPER

VALLEY PAPER

VALLEY PAPER

Wm. H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3705

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3705

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Margaret B Melvin

2. DATE AND HOUR OF DEATH

April 2, 1968

4 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3101 Gibbons Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3101 Gibbons Ave

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

March 5, 1904

9. AGE (In years last birthday)

64

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Hintenach

14. MOTHER'S MAIDEN NAME

Margaret Dillmann

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Virginia Rose 1902 Glen Ridge Ave #34

18.

410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Coronary Thrombosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Rheumatic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day

25 yrs

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from June 7, 1963 to April 2, 1968, that (I) (we) last saw the deceased alive on April 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Charles W Edmonds M.D.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

April 4, 1968

23C. PHYSICIAN'S NAME (Type)

Charles W Edmonds M.D.

DEGREE

23D. ADDRESS

2746 The Alameda

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/5/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc. Baltimore, Maryland

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3706	
J-525		68- 3706		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Johnson, Wallace W.</i>		2. DATE AND HOUR OF DEATH <i>4/4/68 1:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto. City</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		E. STREET AND NUMBER <i>1610 N. Calveek Street</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/4/1892</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>America</i>		13. FATHER'S NAME <i>(Unknown) Johnson</i>		14. MOTHER'S MARDEN NAME <i>Julia (Unknown)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1917-18</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Harold Holly (Son)</i>	
ADDRESS <i>Same as deceased</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE - <i>Hypertatic pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Cardiac arrest &amp; paraplegia</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <i>Mild atherosclerosis</i>					
334 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>3/20/1968</i> to <i>4/4/1968</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>4/3/1968</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>Dermot Campbell MD</i>				23B. DATE SIGNED <i>4/4/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DERMOT CAMPBELL MD</i>				23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL Union Memorial Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-8-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>	
25C. FUNERAL DIRECTOR <i>Charles R. Law</i>		25D. ADDRESS <i>802 Madison Ave.</i>			

Handwritten notes, possibly a list or index, located in the upper left quadrant of the page.

Handwritten notes, possibly a list or index, located in the upper right quadrant of the page.

Handwritten notes, possibly a list or index, located in the middle section of the page.

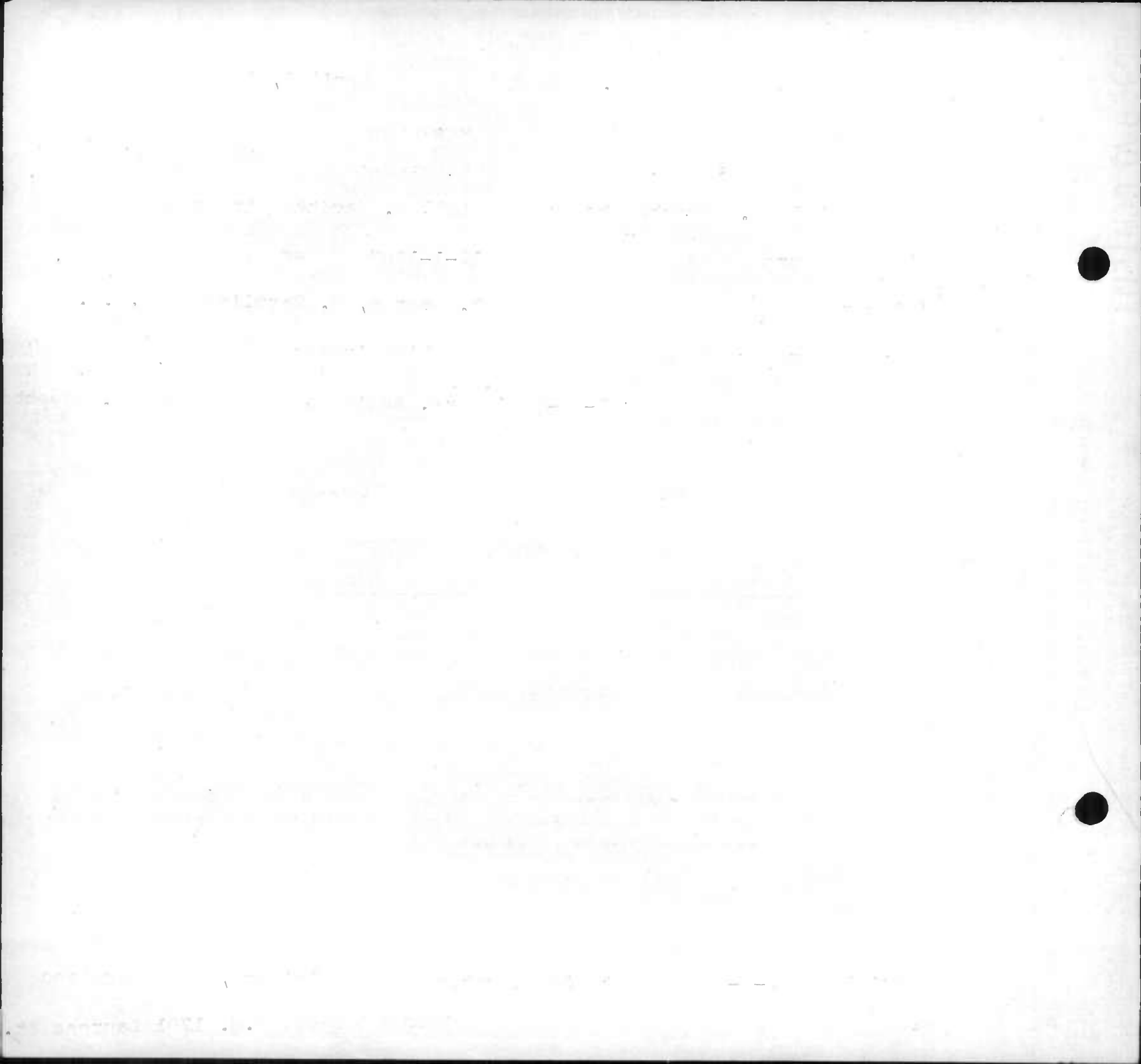
Handwritten notes, possibly a list or index, located in the lower left quadrant of the page.

Handwritten notes, possibly a list or index, located in the lower right quadrant of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68-3707</span>	
B-653 68-3707 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<b>ELDER WESLEY O. BRYANT</b>		<b>April 3, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
			B. COUNTY		
1812 W. Fayette Street			MARYLAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN		
			BALTIMORE		
			E. STREET AND NUMBER		
			1812 W. Fayette Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-1-1907	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Minister				U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Bryant			Eliza Bryant		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		263-05-7823		Mrs. Annie Mae Bryant 1812 W. Fayette	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Arteriosclerotic Cardiovascular disease		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from August 1967 to March 1968 that (I) (we) last saw the deceased alive on March 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Royston B. Scott				April 8, 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ROYSTON B. SCOTT				1801 W. BALTIMORE ST	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-6-68		Mount Zion Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 5 1968		Robert E. Fisher		MORTON & DYETT F.H. 1701 Laurens St.	



1  
M-240 68-3708 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-3708

BIRTH NO.		1. NAME OF DECEASED (Type or Print) TONYA McCALL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 2, 1968 Hour 1:40 P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year April 2, 1968 Hour 1:40 P M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 8-4-66	10. AGE (In years last birthday) 20	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1635 Hakesley Place		
11. BIRTHPLACE (State or foreign country) Balt. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Codell McCall		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Janice Monroe		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. None	18. INFORMANT Mrs. Janice Monroe		ADDRESS 1635 Hakesley Pl.
19. E 8841X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  E 902.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Laceration of liver and spleen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1635 Hakesley Place	
22D. TIME OF INJURY (Approx.) 3 30 68 unk. m.		22E. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Allegedly fell from chair	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-3-68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-68	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 5 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.	
ADDRESS 1701 Laurens St.					

Gen. N. K. K.

B-436

68-3709

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3709

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MAZZIE JANETT BULTER

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ April 2, 1968 6:30 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
HOSPITAL OR INSTITUTION ADDRESS AND CITY)

1720 Warwick Avenue (DOA) 5/14/68

3. DATE PRONOUNCED DEAD Month Day Year Hour  
April 2, 1968 6:30 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY6. SEX  
Female7. RACE  
Negro8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐C. CITY OR TOWN  
BaltimoreD. INSIDE CITY LIMITS? YES ☒ NO ☐9. DATE OF BIRTH 1888  
5-15-1810. AGE (In years  
lost birthday) 79If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.E. STREET AND NUMBER  
1720 Warwick Avenue11. BIRTHPLACE (State or foreign country)  
Va12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.13. FATHER'S NAME  
William H. Jones14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)  
Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME  
Marie Jackson16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT ADDRESS  
Family same19. 412.9 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)CAUSE OF DEATH  
Arteriosclerotic Cardiovascular DiseaseAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
No22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE *Ronald N. Kornblum* M.D.  
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-3-6824A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

4-7-68

Mt. Calvary Cem. A. A. Co.

Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR 1011-13 ADDRESS

APR 5 1968

Robert E. Fairbank

Sullivan Funeral Home - N. Arlington Ave

5/16/68 - Insurance policy from ~~State~~  
Stat Life Insurance Co. #1529849.

*ABC.*

A-6531

68- 3710

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3710

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MARY ARNETT

2. DATE AND HOUR OF DEATH

3/29/68

6:25A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)33 THE JOHNS HOPKINS HOSPITAL  
601 N. BROADWAY  
BALTIMORE, Md. 21205

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

1803 BARCLAY STREET

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5. SEX

FEMALE

6. RACE

NEGROID

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2/07/20

9. AGE (In years  
lost birthday)

48 YRS.

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Abbeyville, S. Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ELEX MORRIS

14. MOTHER'S MAIDEN NAME

AZALEE COLE

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Richard Brooks 4011 Ridgewood Ave

18.

E 8901X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating  
UNDERLYING CONDITION last.

19. CAUSE OF DEATH

A. IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

SEPTICEMIA

40% 2°-3° BODY BURNS.

DUE TO, OR AS A CONSEQUENCE OF:

DIABETES MELLITUS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

18 HOURS

36 DAYS

3 YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3-16, 3-25-68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

BURN DEBRIDEMENT

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)☒21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

HOME

21C. WHERE DID  
INJURY OCCUR?

1803 BARCLAY ST., BALTIMORE, MD.

21D. TIME  
OF INJURY

(APPROX.)

(Month) (Day) (Year) (Hour)

2 - 21 - 68

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☒

21F. HOW DID INJURY OCCUR?

KEROSENE IGNITED.

22. I certify that (I) (this hospital) attended the deceased from 2/29 1968 to 3/29 1968,  
that (I) (we) last saw the deceased alive on 3/29 1968 and that in my (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

23A. SIGNATURE

Katsuji Kubo

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

3/29-68

23C. PHYSICIAN'S  
NAME (Type)

KATSUJI KUBO, MD

23D. ADDRESS

JOHNS HOPKINS HOSPITAL  
BALTIMORE, MARYLAND24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-5-68

24C. NAME OF CEMETERY or CREMATORY

Abbeyville Cem.

24D. LOCATION

Abbeyville, South Carolina

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1968

25B. NAME OF REGISTRAR

Robert E. Fisher

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

18 hours  
30 days

SEPTICEMIA

40% 2-3. Body Burns

DIABETES MELLITUS

GRAN DEBRIDEMENT

2-10-72-68

Yes

Yes

X

HOME

2-21-68

1803 BUCKINGHAM ST. BIRMINGHAM, ALA.

KEROSENE IGNITED

X

3/24/68

2/24/68

3/24/68

X

JOHN HOOKING HOSPITAL  
BIRMINGHAM, ALA.

KATSUMI KUBO MD

*Katsumi Kubo*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 3711 CERTIFICATE OF DEATH

REG. NO. 68- 3711

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES FRANK URBAN</b>		2. DATE AND HOUR OF DEATH <b>April 5, 1968 2:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE-CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>624 N. DECKER AVE</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>624 N. DECKER AVE</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 15, 1893</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CANNERY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ANTHONY W. URBAN</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIE MUSIL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-7807</b>		17. INFORMANT <b>MARY URBAN 624 N. DECKER AVE.</b>	
18. <b>199.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac De compensation</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Metastatic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>March 1 1968</b> to <b>April 5 1968</b> , that (I) (we) last saw the deceased alive on <b>April 5 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Charles F. MacMinn M.D.</b> DEGREE	
23B. DATE SIGNED <b>Apr 8, 1968</b>		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Road Balti Md</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>	
25C. FUNERAL DIRECTOR <b>Fredrick D. Muller Inc 3019 E. Monument St</b>		25D. ADDRESS		25E. ADDRESS	

October 1892

the last of the year

the first of the year

the first of the year

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 3712	
68- 3712 CERTIFICATE OF DEATH				REG. NO. 68- 3712	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		COFFIN, Roscoe Tristram		5 APRIL 1968 7:55 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
23 VETERANS ADMINISTRATION HOSPITAL			MARYLAND BALTIMORE CITY		
3900 LOCH RAVEN BOULEVARD			C. CITY OR TOWN		
BALTIMORE, MARYLAND 21218			BALTIMORE		
			D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			1420 BOLTON STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	CAUCASION	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-2-97	71	SECURITY GUARD
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SECURITY GUARD		DEPARTMENT STORE		BALTIMORE, MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ROSCOE L COFFIN			MARY KRONMILLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 4-6-42 TO 7-28-46		215-09-24-81		V A HOSPITAL RECORDS 3900 LOCH RAVEN BLVD., BALTO., MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			PERIPHERAL VASCULAR COLLAPSE 12 DAYS		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ANOXIA, RESPIRATORY ACIDOSIS 18 DAYS		
			(C) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YEARS		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
5-27-2			NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
			21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from 20 MARCH 19 68 to 5 APRIL 19 68, that (we) lost saw the deceased alive on 5 APRIL 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
GORDON F. MURRAY			4-5-68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Gordon F. Murray MD.			3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Apr. 9, 1968		Crest Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 9 1968		Robert E. Faulkner		Howard County Fun. Home of Harry H. Witzke 321 Columbia Pike, Ellicott City, Md., 21043	

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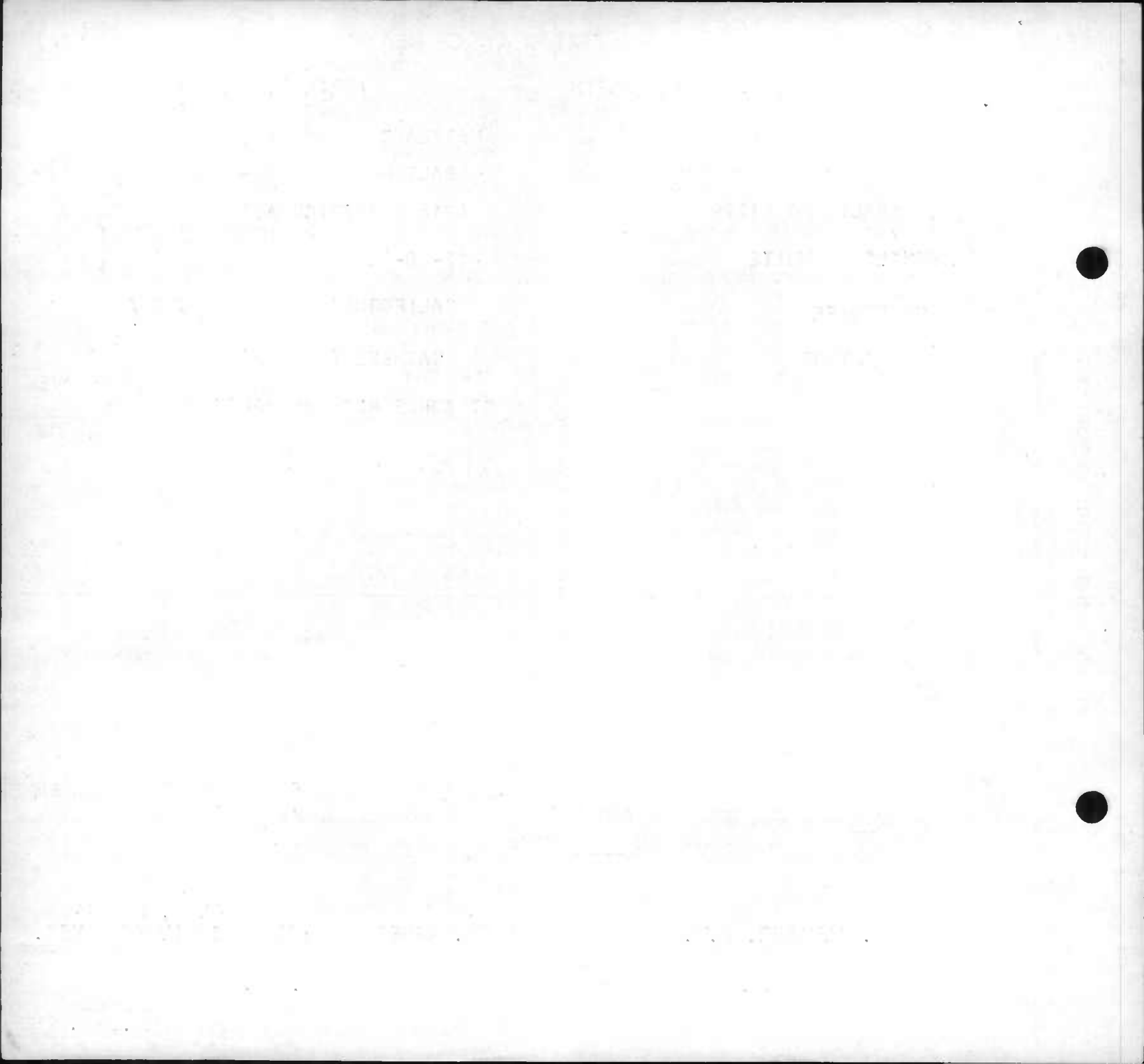
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 3713</u>
BIRTH NO. <u>B1400</u>		68- 3713 <b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>BOEHL, MARIE ELIZABETH</b>		2. DATE AND HOUR OF DEATH <b>APRIL 4, 1968 8 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO MD 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <b>4718 FREDERICK AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-40</b>	9. AGE (In years last birthday) <b>27</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA</b>
13. FATHER'S NAME <b>ARTHUR</b>		14. MOTHER'S MAIDEN NAME <b>KATHLEEN(BONTER)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CATON &amp; WILKENS AVE ST AGNES RECORDS BALTO MD 21229</b>
18. <b>250.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE Hemorrhagic Pancreatitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Secondary Intraabdominal Fat Necrosis.</b> <b>Severe Diabetic Ketoacidosis.</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>260X II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 4 19 68</b> to <b>APRIL 4 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 4 19 68</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.				
23A. SIGNATURE <b>M. Alvarez M.D.</b>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>M. ALVAREZ, M.D.</b>		23D. ADDRESS <b>BALTO, MD 21229 ST. AGNES HOSP; CATON &amp; WILKENS AVES.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-8-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>R. E. Taylor</b>	25C. FUNERAL DIRECTOR <b>4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HENRY C. HARRIS, Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>April 5, 1968</b>		Hour <b>2:05 P M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD <b>April 5, 1968</b>		Hour <b>2:05 P M.</b>
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>Jan. 1, 1947</b>		10. AGE (In years lost birthday) <b>21</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>104 S. Gilmore St.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Juanita Tellez</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-44-9998</b>		18. INFORMANT <b>Mrs. Juanita Tellez</b>
		20 Pebble Drive ADDRESS		<b>Balto, Md. 21225</b>

MEDICAL CERTIFICATION	19. CAUSE OF DEATH <b>E884 IX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
	21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION <b>4-5-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Head injuries</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Shipyard</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Bethlehem Shipyard, Sparrows Point</b>
22D. TIME OF INJURY (APPROX.) <b>4-5-68 9:15 A m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell from plank to deck of ship</b>

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Charles S. Springate</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-6-68</b>
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-8-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Charlottesville, Va.</b>	24D. LOCATION (City, town, or county) (State) <b>Witzke Funeral Directors, Balto., Md. 21229</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>		ADDRESS <b>4101 Edmondson Avenue</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 3715</u>
P-300		68- 3715		<b>CERTIFICATE OF DEATH</b>
1. NAME OF DECEASED (Type or Print) <b>Harold J. Potee</b>		2. DATE AND HOUR OF DEATH <b>April 5, 1968</b> <b>10:35 PM.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5-21-68</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 21218 B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/19/02</b> 9. AGE (In years last birthday) <b>65</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>York Coregated Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George E.</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Fogle</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-0779A</b> 17. INFORMANT <b>Mrs. George M. Potee, Balto., Md. 21218</b>		
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) <b>Widespread metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Adenocarcinoma Rt. Lung</b>		CAUSE OF DEATH <b>Mrs. Garnetta M. Potee, 3619 Elm St. Balto., Md. 21218</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Actual fibrillation</b>		
19A. DATE OF OPERATION <b>02-15-68</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rt. lung mass</b>		20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from <b>1-20-68</b> to <b>4-5-68</b> , that (I) last saw the deceased alive on <b>4-5-68</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.				
23A. SIGNATURE <b>Richard H. Mack, M.D.</b>		23B. DATE SIGNED <b>4-6-68</b>		
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Mack, M.D.</b>		23D. ADDRESS <b>SOUTH BALTIMORE GENERAL HOSPITAL 1213 Light Street Balto., Md. 21230</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-8-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>
24D. LOCATION <b>Balto., Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 9 1968</b> 25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		
25C. FUNERAL DIRECTOR <b>4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229</b>		ADDRESS		

V.S. 153

5-21-68

M.H.

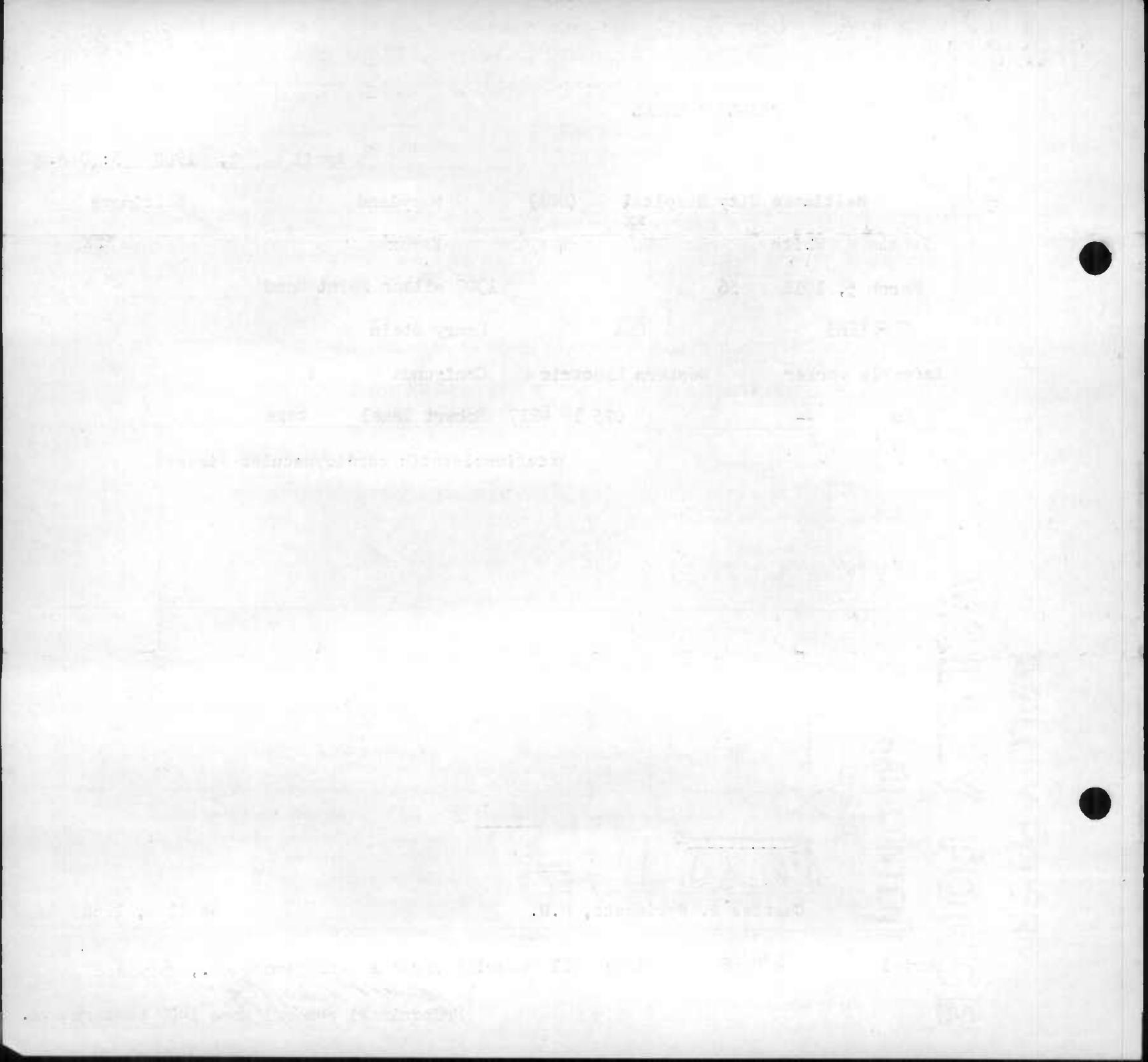
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-3716

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>URSULA IEKEL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 4, 1968 5:20 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Essex</b>	
9. DATE OF BIRTH <b>March 5, 1912</b>		10. AGE (In years lost birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembly Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>075 16 4217</b>	
15. MOTHER'S MAIDEN NAME <b>Conigunda ?</b>		18. INFORMANT <b>Robert Iekel</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>422.1 II</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 4, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/8/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holly Hill Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home</b>		ADDRESS <b>1407 Eastern Ave.</b>	

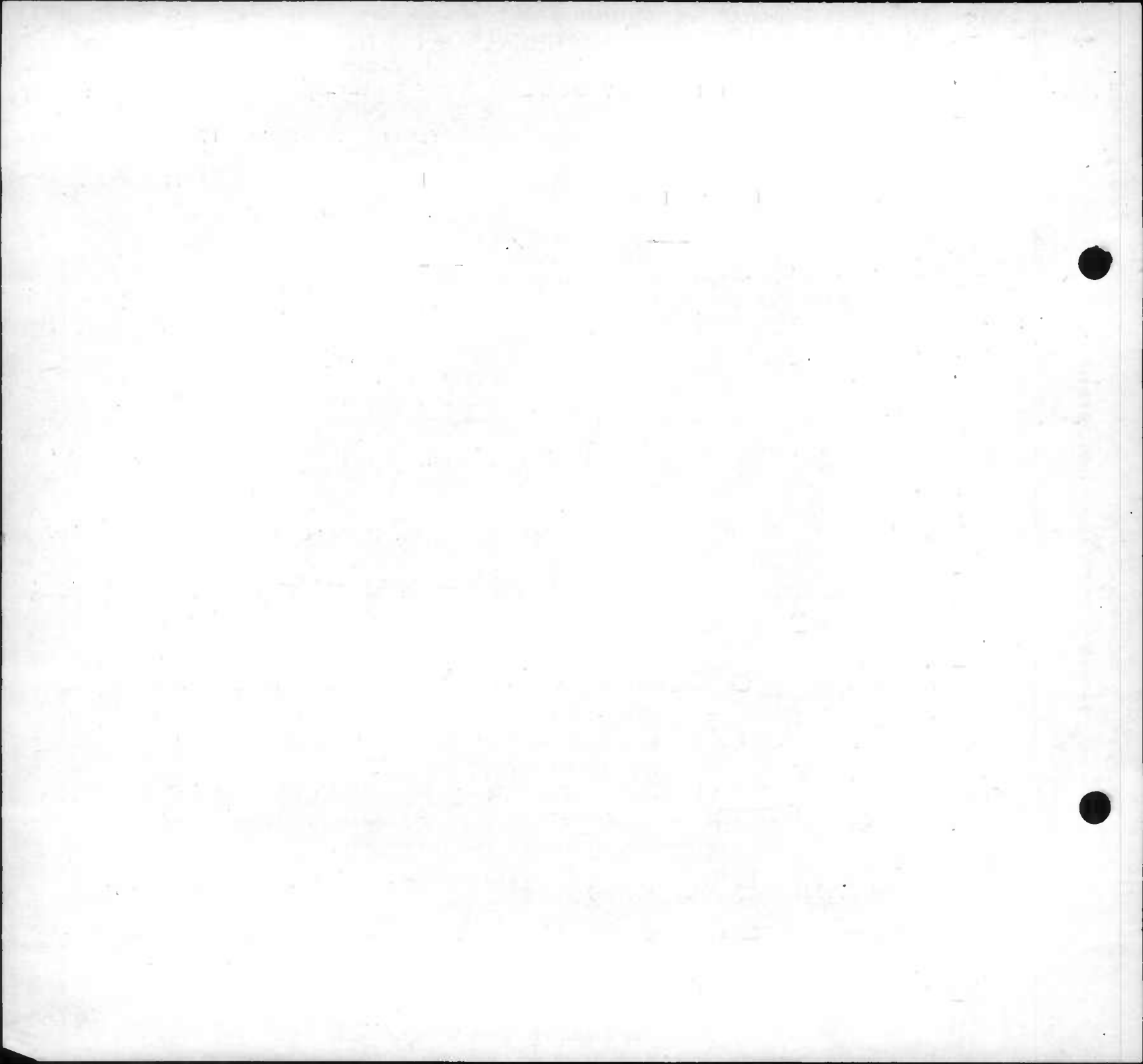


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
68- 3717		68- 3717	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
PATRICIA FARLEY SOUL		4-5-68 6:15 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND	
		B. COUNTY BALTIMORE CITY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 203 N. Belmond Ave.	
5. SEX FEMALE	6. RACE WHITE	7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-40
9. AGE (In years last birthday) 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES SOUL		14. MOTHER'S MAIDEN NAME ANN LOPATA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-38-5002	
17. INFORMANT James J. Soul		ADDRESS 203 N. Belmond Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH Respiratory failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Toxic depression (B) DUE TO, OR AS A CONSEQUENCE OF:  Hepatic failure (C) DUE TO, OR AS A CONSEQUENCE OF:  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min. 24 hours Several days			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 3-8-3X II			
19A. DATE OF OPERATION 4-4-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute abdomen - lap.	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0	
21C. WHERE DID INJURY OCCUR? 0		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) 0		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? 0			
22. I certify that (I) (this hospital) attended the deceased from 4-3 1968 to 4-5 1968, that (I) (we) last saw the deceased alive on 4-5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Bertram Z Arins, M.D.		23B. DATE SIGNED 4-5-68	
23C. PHYSICIAN'S NAME (Type) BERTRAM Z ARINS		23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTO, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 8/1968	
24C. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968		25B. NAME OF REGISTRAR Philip E. Farley	
25C. FUNERAL DIRECTOR Philip E. Farley		ADDRESS 1211 Chesaco Ave	



FUNERAL DIRECTOR: IMPORTANT

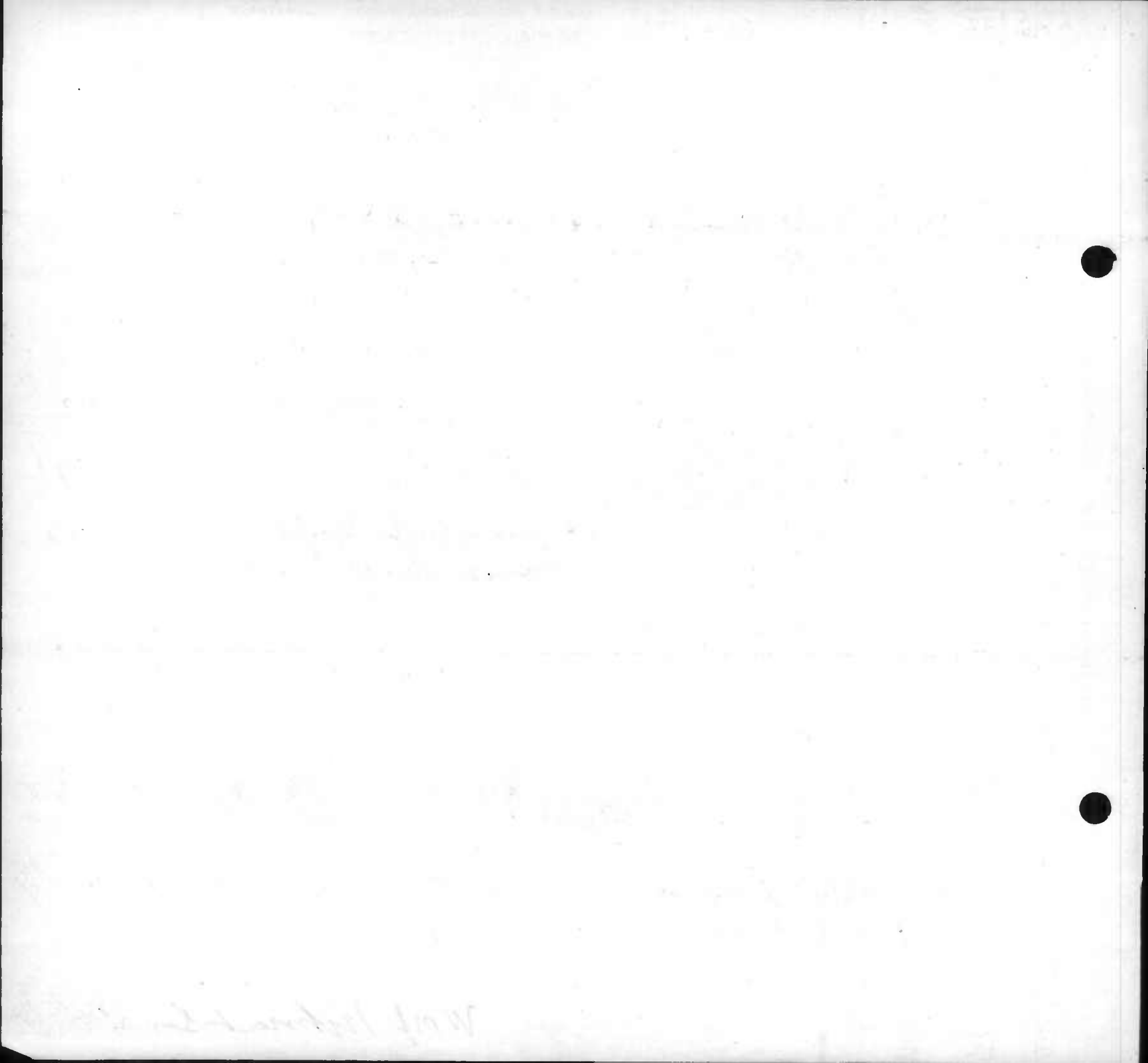
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3718

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3718

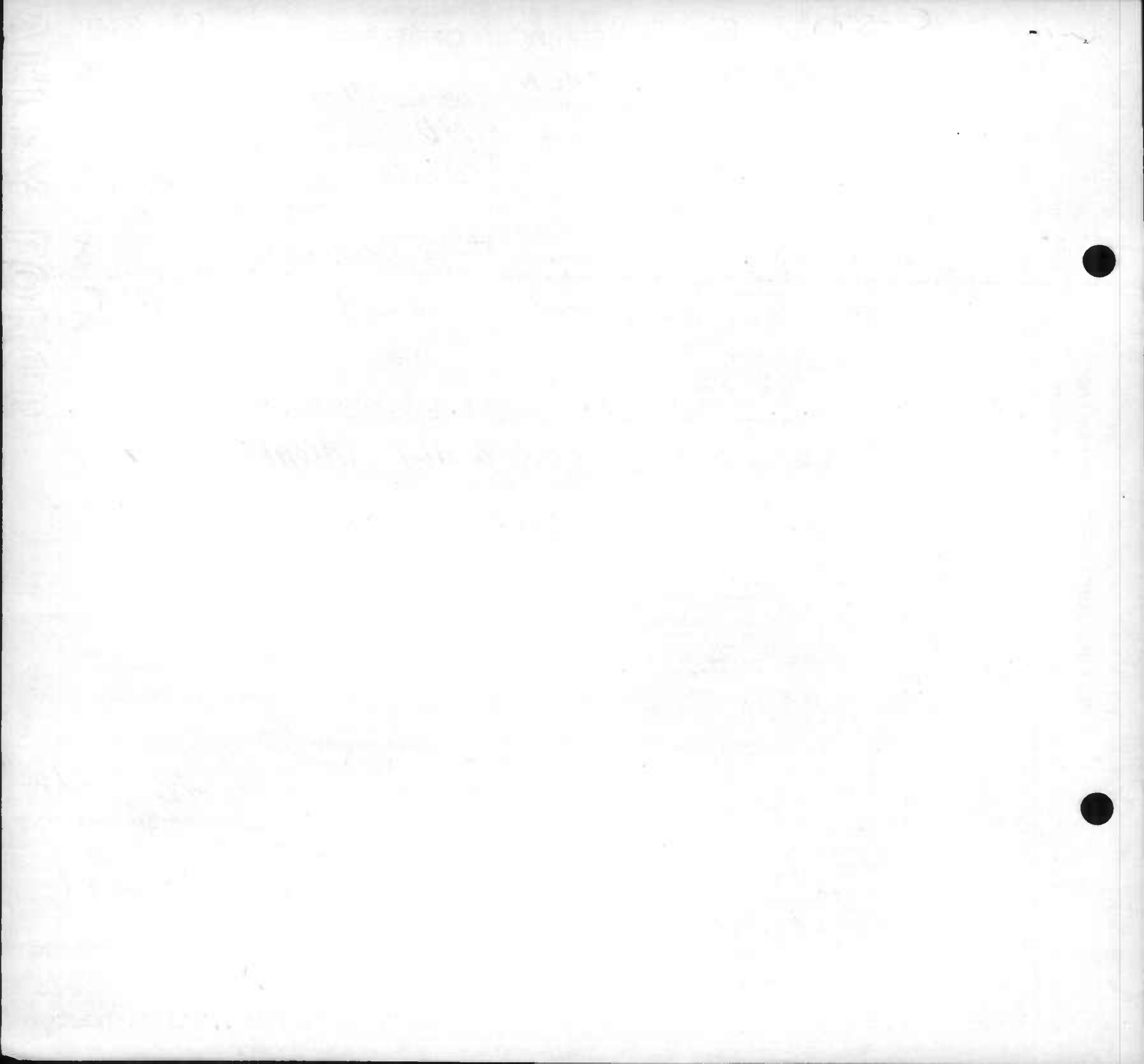
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Loretta Brown</b>		2. DATE AND HOUR OF DEATH <b>April 3, 1968</b> <b>8 AM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1600 East 28th Street Baltimore, Md. 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1600 East 28th Street</b> <b>18</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1880</b>	9. AGE (In years last birthday) <b>87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Francis Patrick Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Mary Jane Quinn</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Mamie Brown</b> same address as above	
18. <b>404X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio Sclerotic Cardio</b> <b>Vascular Renal Disease</b>			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>5 yrs.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>442X II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 10</b> 19 <b>63</b> to <b>April 3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 2</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chas Wm Edmunds MD</b>				23B. DATE SIGNED <b>April 4, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Chas. Wm Edmunds MD</b>		23D. ADDRESS <b>2746 The Alameda</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE RECORDED <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR <b>Wm J. Libman</b>	
ADDRESS		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
C-500 68- 3719 CERTIFICATE OF DEATH									
REG. NO. 68- 3719									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>ABRAHAM B. COHEN</b>					2. DATE AND HOUR OF DEATH <b>4/2/68</b> <b>3 30 A.M.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP OF BALTO.</b>					C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-10-1886</b>		9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>CHARLES COHEN</b>					14. MOTHER'S MAIDEN NAME <b>SADIE ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. I ARMY</b>					16. SOCIAL SECURITY NO. <b>212-01-8569</b>		17. INFORMANT ADDRESS <b>MR. LOUIS COHEN, 3835 LABYRINTH RD.</b>		
18. <b>250.91</b> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREB. ART. THROMBOSIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WK</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DIABETES MELLITUS</b>					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF: <b>GEN ASCVD</b>				
					(C)				
19. <b>260 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/2 4/1/68</b> 19 to <b>4/2 68</b> 19 that (I) (we) last saw the deceased alive on <b>4/2 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edward R. Cohen MD</b>					23B. DATE SIGNED <b>4/2/68</b>		23C. PHYSICIAN'S NAME (Type) <b>EDWARD R. COHEN MD</b>		
23D. ADDRESS <b>Sinai</b>					24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				
24B. DATE <b>3-3-68</b>					24C. NAME OF CEMETERY or CREMATORY <b>SHAAREI ZION</b>				
24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>					25A. DATE REC'D BY HEALTH DEPT. <b>APR 8 1968</b>				
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>					25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN</b>				



# FUNERAL DIRECTOR: IMPORTANT

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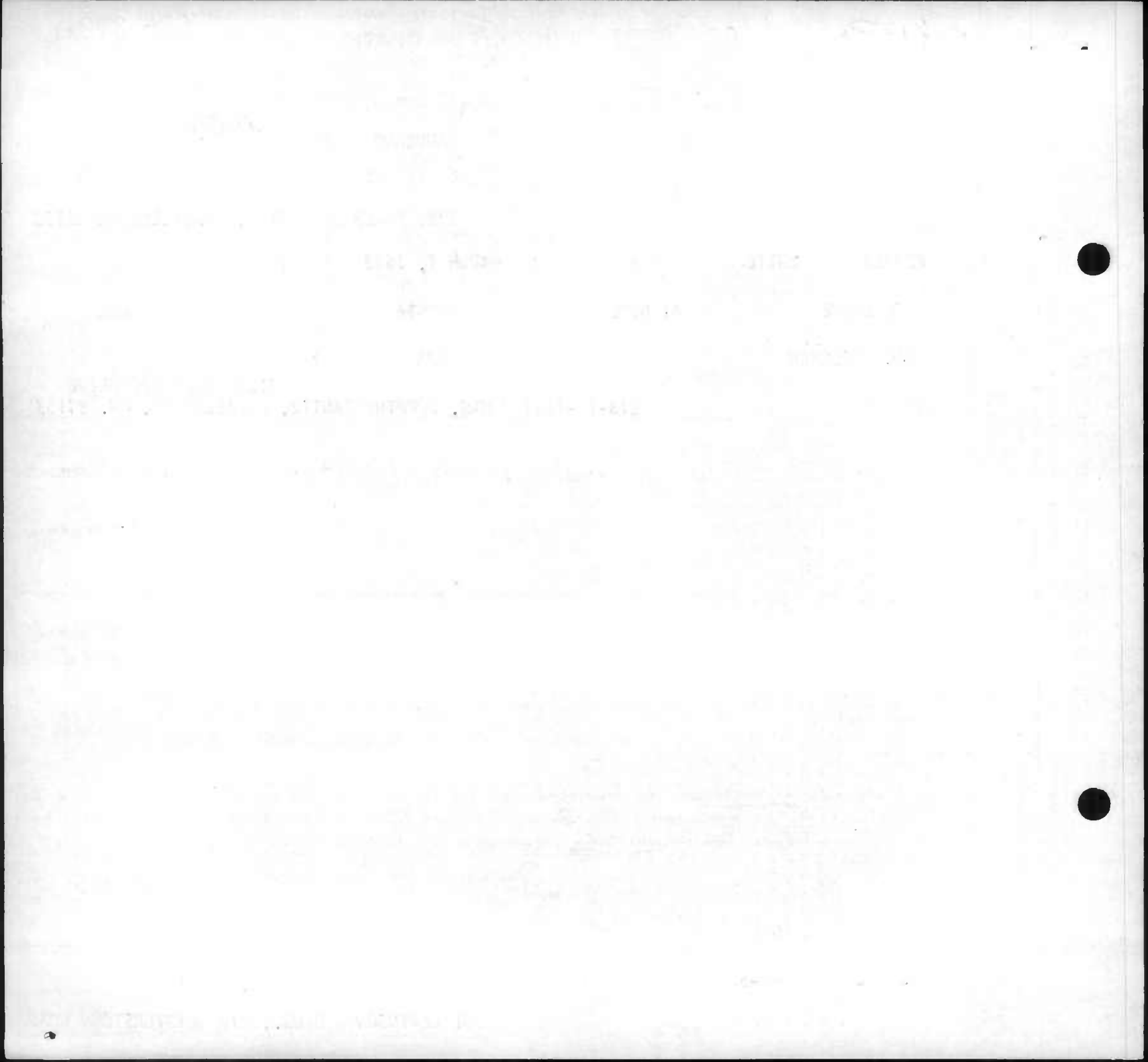
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
5-453 68- 3720				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO. 68- 3720	
1. NAME OF DECEASED (Type or Print) <b>J. ISRAEL SOLOMON</b>			2. DATE AND HOUR OF DEATH <b>4-2-68 9:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI Hosp of Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2541 STEELE ROAD, APT. A</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-26-1900</b>	9. AGE (In years last birthday) <b>68</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CAB COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PA.</b>	
13. FATHER'S NAME <b>ABRAHAM SOLOMON</b>			14. MOTHER'S MAIDEN NAME <b>TILLIE ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>065-10-9873</b>		17. INFORMANT <b>MRS. FANNIE SOLOMON, 2541 STEELE RD., APT. A</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>420.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.0 II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anger heart failure</b> (B) AS H D DUE TO, OR AS A CONSEQUENCE OF: <b>ASHD</b> (C) CA of Colon c Metastasis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-1-68</b> 19 <b>68</b> to <b>4-2</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>April 2</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. Vanasin</b>				23B. DATE SIGNED <b>4-2-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>BOON VANASIN</b>				23D. ADDRESS <b>SINAI Hosp of Balt</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW YOUNG MENS</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Dr. E. F. Johnson</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

UNITED STATES GOVERNMENT

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3721
BIRTH NO. <b>U-340</b>		<b>68- 3721 CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>EVA NEEDLE</b>		2. DATE AND HOUR OF DEATH <b>April 3, 1968 7:20 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3725 PIKESWOOD DRIVE, RANDALLSTOWN 21133</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 1, 1893</b>	9. AGE (In years lost birthday) <b>75</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JACK GRESSER</b>		
14. MOTHER'S MAIDEN NAME <b>IDA ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>213-18-1544 D</b>		17. INFORMATION ADDRESS <b>3725 PIKESWOOD DRIVE MRS. DOROTHY KANITZ, RANDALLSTOWN, MD. 21133</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>151.9 I</b> <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>GI Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Leptomyxoma of stomach</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>unknown</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>151X II</b> <b>Arteriosclerotic cardiovascular disease</b>		<b>unknown</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>3/28</b> 19 <b>68</b> to <b>4/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>K. WETCHER, MD</b>				23B. DATE SIGNED <b>4/3/68</b>
23C. PHYSICIAN'S NAME (Type) <b>K. WETCHER, MD</b>		23D. ADDRESS <b>Sinai Hospital of Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-3-68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>SHOMRE NISHMERES</b>	24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>



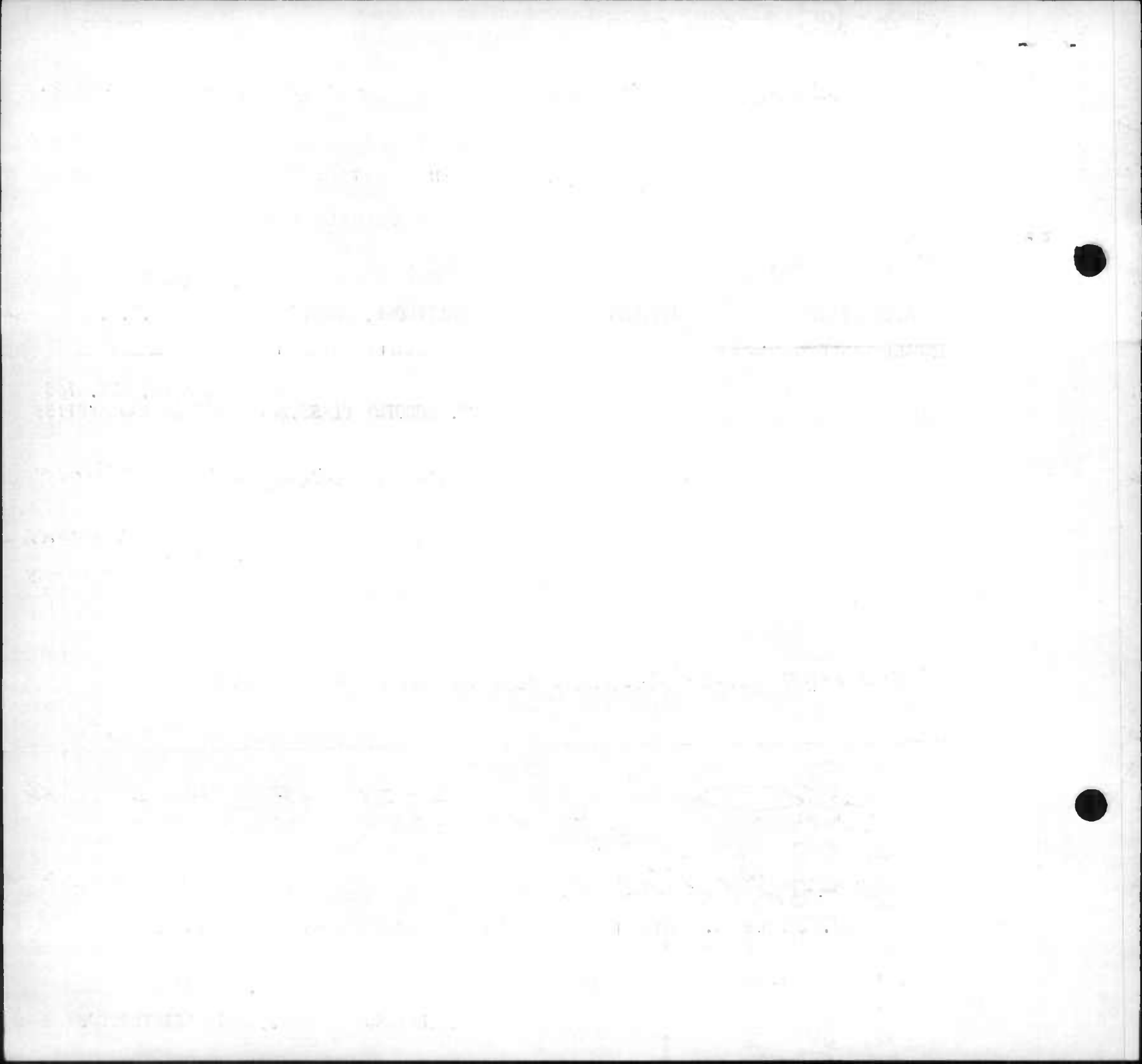
1280190

Class. Sidney

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-420		68-3722		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3722		
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>CLASS, SIDNEY L.</u>				
2. DATE AND HOUR OF DEATH <u>4-4-68</u> 1:06 P. M.								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>				C. CITY OR TOWN <u>RANDALLSTOWN</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>8618 BRAMBLE LANE</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/18</u>	9. AGE (In years lost birthday) <u>49</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ISRAEL MOXXIX CLASS</u>				14. MOTHER'S MAIDEN NAME <u>SONIA SMORDIN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. DOROTHY CLASS</u>		
				ADDRESS <u>FOX HALL APTS, APT. 103</u>		<u>8618 BRAMBLE LANE #21133</u>		
18. <u>044X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>081X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>SEVERE PULMONARY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>POST POLIO</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>5 YEARS</u> <u>48 YEARS</u>
19A. DATE OF OPERATION <u>3-26-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SEVERE PULMONARY INSUFFICIENCY</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>2-26-68</u> to <u>4-4-68</u> , that (I) (we) last saw the deceased alive on <u>4-4-68</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>James L. Phillips M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-4-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>DR. JAMES L. PHILLIPS</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-5-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH JACOB</u>		24D. LOCATION (City, town, or county) (State) <u>FINKSBURG, MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		ADDRESS		

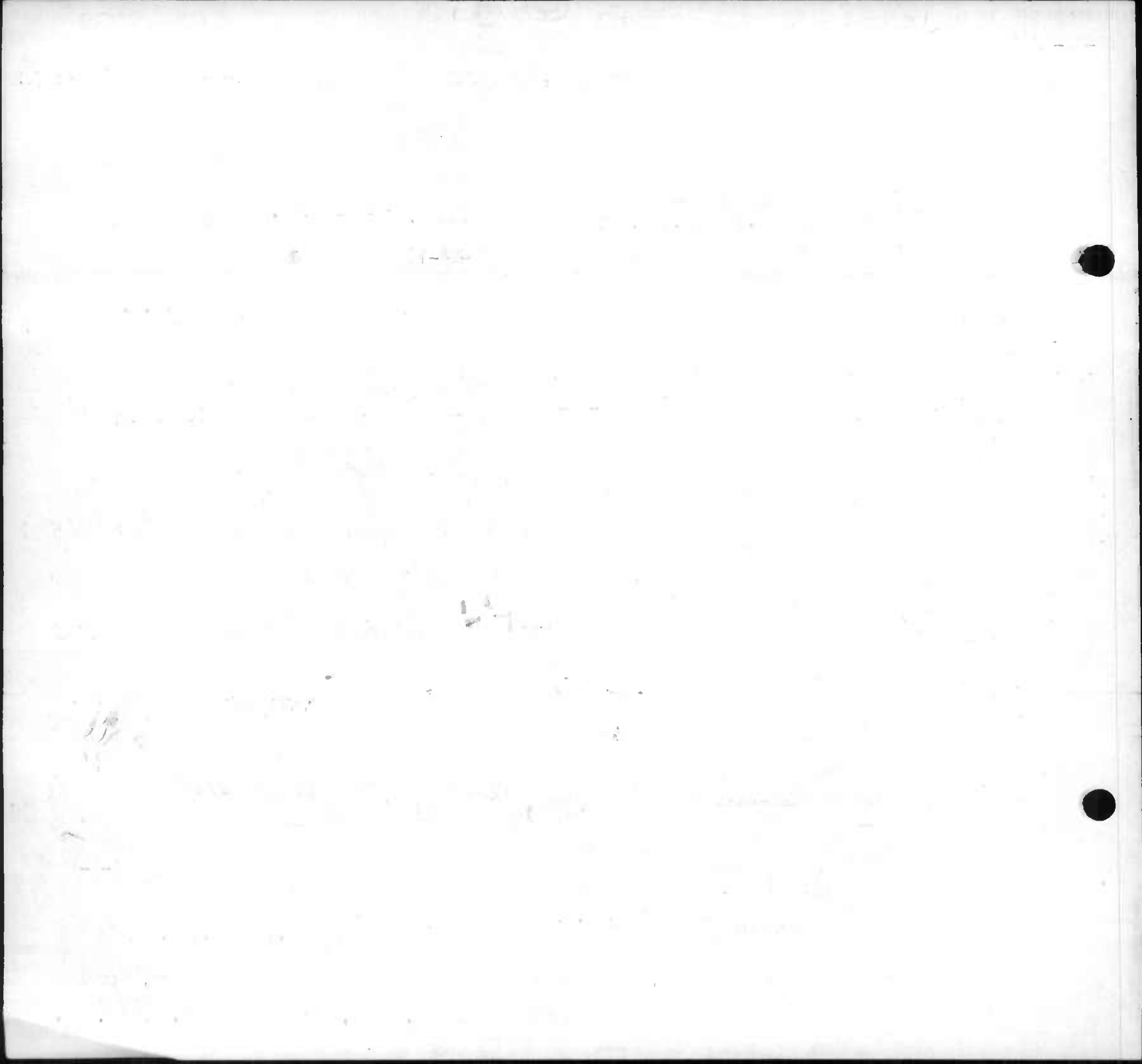


49-53-84-1B

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		68-3723		BALTIMORE CITY HEALTH DEPT.		REG. NO. 68-3723	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JENKINS, JOSEPHINE</b>			
2. DATE AND HOUR OF DEATH <b>4/4/68 4:45 PM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>702 S. Ellwood Ave. #21224 007</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-16</b>	9. AGE In years <b>51</b>	10. If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BOGUCKI</b>				14. MOTHER'S MAIDEN NAME <b>EVA NOVAK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-8491</b>		17. INFORMANT <b>RECORDS: BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE BALTO., MD. #21224</b>			
18. <b>404 X I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Renal + respiratory failure</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CVA 2° cerebral embolism</b>		<b>3/24/1968</b>			
		(C) <b>Atrial flutter. Cardiomegaly</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>4-3 X II</b>		<b>Hypertension probably 2° renal</b>		<b>Since 1963</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/24/1968</b> to <b>4/4/1968</b> that (I) (we) last saw the deceased alive on <b>3 p.m. 4/4/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David Juan</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/4/1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID JUAN, M.D.</b>				23D. ADDRESS <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>2829 Hudson St. Balto. Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

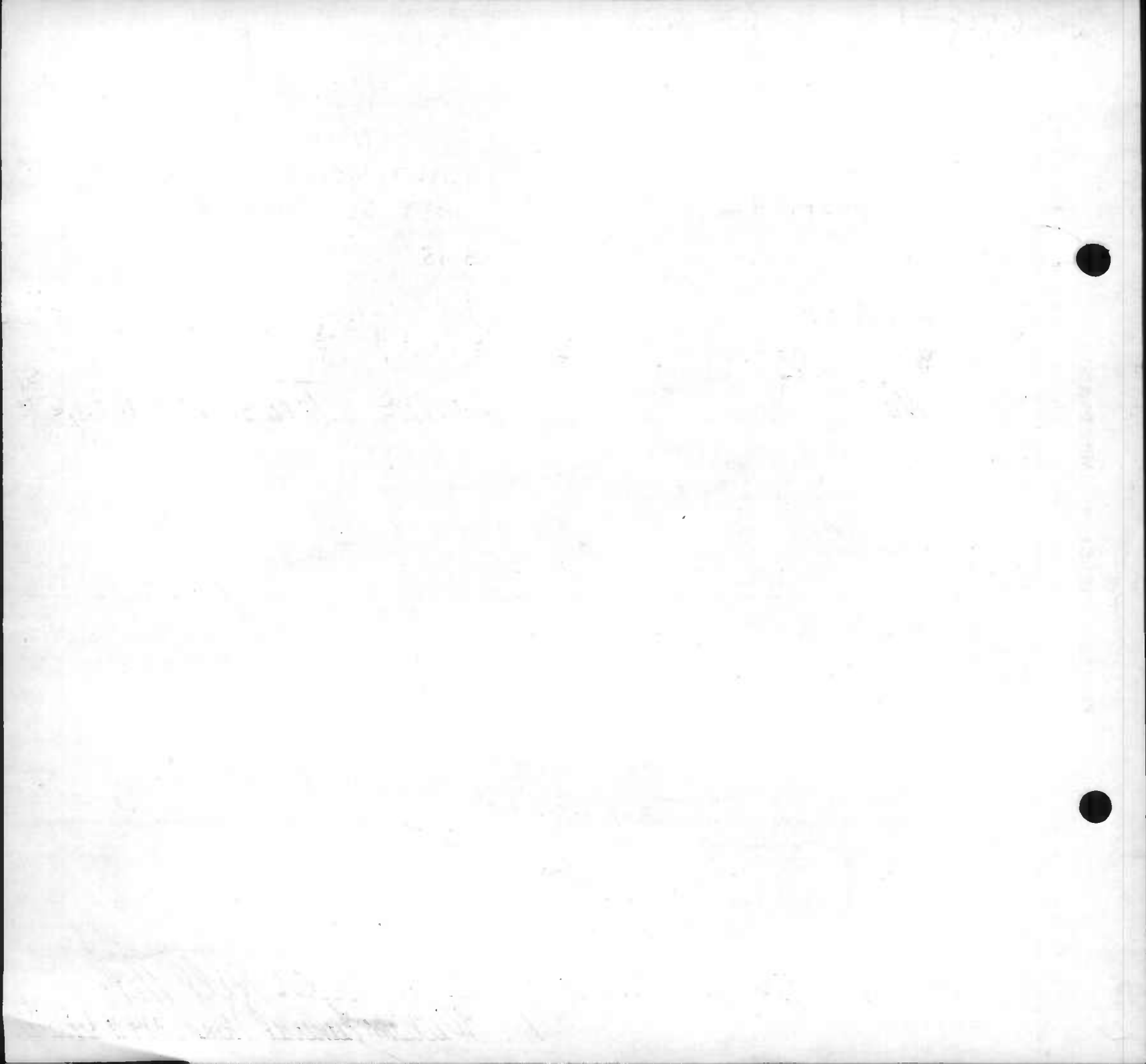
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3724

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3724

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>OVELTON FREEMAN</b>		2. DATE AND HOUR OF DEATH <b>4/2/68 8:13 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY 38 HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/00</b>	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BUCK FREEMAN</b>		14. MOTHER'S MAIDEN NAME <b>DORA P</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Lucille Turner</b>	
ADDRESS <b>1033 W. Fayette St.</b>					
18. <b>53191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MALNUTRITION</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>MALNUTRITION</b>		MONTHS <b>MONTHS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>540.0 II</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>GASTRIC ULCER</b>		MONTHS <b>MONTHS</b>	
19A. DATE OF OPERATION <b>03/20/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC ULCER</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>68</b> to <b>4/2</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/2/68</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles M. Harrison</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/2/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES M. HARRISON</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>		25A. DATE RECD BY HEALTH DEPT. <b>4/8/68</b>			
25B. NAME OF REGISTRAR <b>William J. Harrison</b>		25C. FUNERAL DIRECTOR <b>William J. Harrison</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3725

**CERTIFICATE OF DEATH**

REG. NO. 68- 3725

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lillian M Cross</u>		2. DATE AND HOUR OF DEATH <u>April 6, 1968</u> <u>11:10 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balt</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3747 Elm Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-86</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Harry G Ricketts</u>		14. MOTHER'S MAIDEN NAME <u>Neva Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-76953</u>		17. INFORMANT <u>Bryan O. Cross</u>	
				ADDRESS <u>-3747 Elm Ave.</u>	
18. <u>447.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dissecting aneurysm of abdominal aorta</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>W. K. C. W.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>451X II</u>					
19A. DATE OF OPERATION <u>8</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Oct 15</u> 19 <u>67</u> to <u>April 6</u> 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 6</u> 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <del>did</del> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <u>Alan B Cohen MD</u>				23B. DATE SIGNED <u>April 6, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR ALAN B COHEN</u>				23D. ADDRESS <u>3501 ST PAUL ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Austin E. Donovan</u>	
				ADDRESS <u>-3818 Roland Ave.</u>	

Dear Mother

Dear Mother

I am so glad to hear from you and hope you are all well.

Yours truly,

Yours truly,

D-100

68- 3726 BALTIMORE CITY HEALTH DEPARTMENT

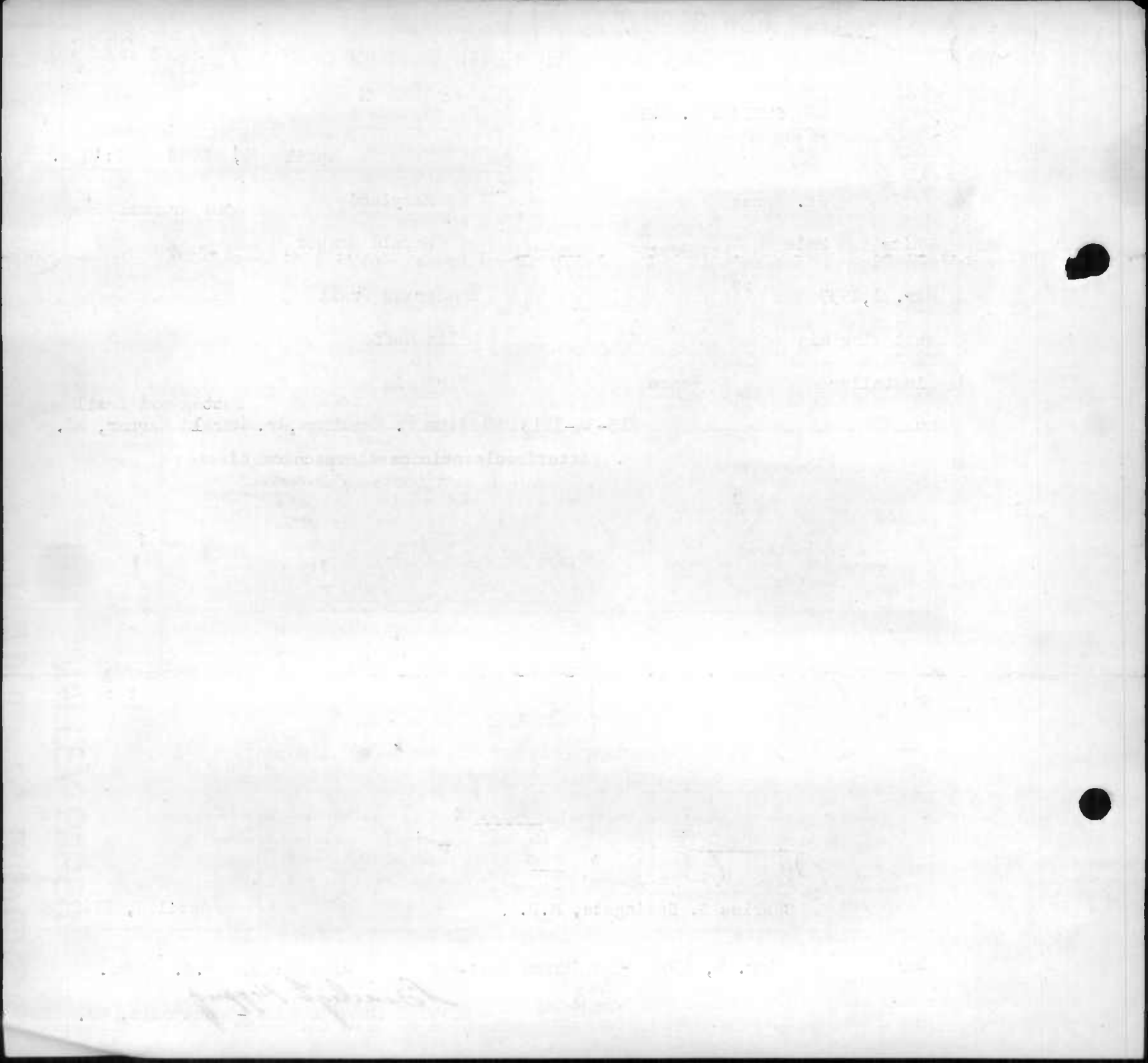
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3726

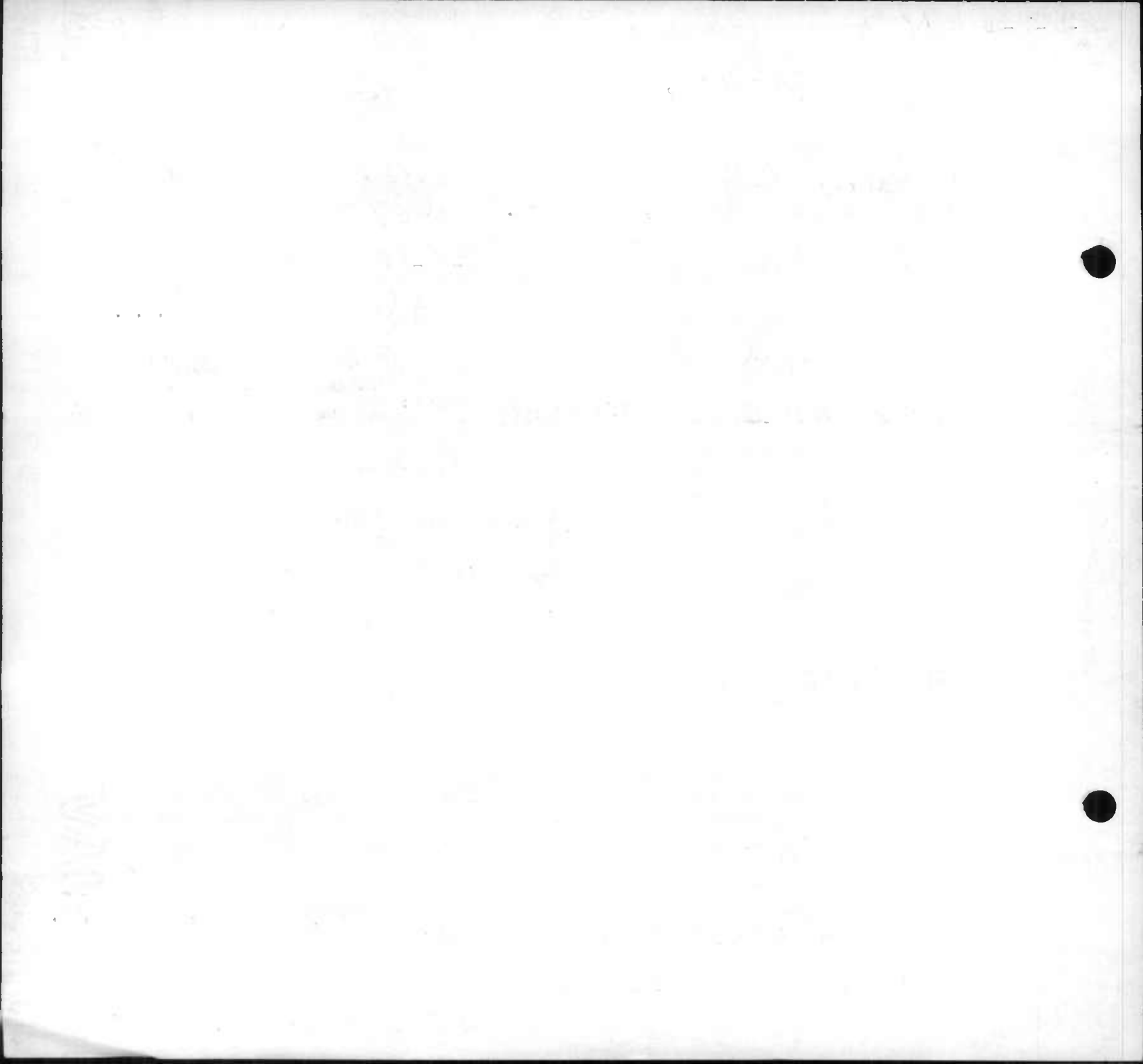
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>STEVENS E. DAFF</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 4, 1968 7:10 A.</b> M.	
6. SEX <b>White</b>		7. RACE <b>Male</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Herald Harbor</b>	
9. DATE OF BIRTH <b>Mar. 1, 1939</b>		10. AGE (In years lost birthday) <b>29</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>installer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Fence</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>215-34-1213</b>	
15. MOTHER'S MAIDEN NAME <b>Virginia</b>		18. INFORMANT <b>William P. Hastings, Jr.</b>	
19. <b>412.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>April 4, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 8, 1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie A.A. Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>	
25C. FUNERAL DIRECTOR <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3727	
BIRTH NO. N-550 68-3727					
1. NAME OF DECEASED (Type or Print) Noonan, Isabelle			2. DATE AND HOUR OF DEATH 4/3/68 10 <sup>05</sup> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Balto. City Hospitals 4940 Eastern Avenue, Baltimore, Md.			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 467 Torner Rd. 21221		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-18	9. AGE (In years last birthday) 49	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Johnson			14. MOTHER'S MAIDEN NAME Ella Worsham		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII			16. SOCIAL SECURITY NO. 418-14-1880		17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue, 21224
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Failure sq. cell Ca of pericardium (B) DUE TO, OR AS A CONSEQUENCE OF: sq. cell Ca of G. (C) Renal Failure.		
19A. DATE OF OPERATION 3/26/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Constructive pericarditis		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/26 to 4/3 1968, that (I) (we) last saw the deceased alive on 4/3/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Kokshanian			23B. DATE SIGNED 4/3/68		
23C. PHYSICIAN'S NAME (Type) A. KOKSHANIAN			23D. ADDRESS Balto City 4940 Eastern Avenue, Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/8/68	24C. NAME of CEMETERY or CREMATORY BALTO. NATL.		24D. LOCATION (City, town, or county) BALTO. MD. (State)
25A. DATE REC'D BY HEALTH DEPT. APR 8 1968		25B. NAME OF REGISTRAR E. J. Kelly		25C. FUNERAL DIRECTOR J.G. CONNELLY SONS ADDRESS 300 MACC	



68- 3728

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3728

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RICHARD HOWARD CARTER JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 3, 1968 3:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 CITY HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 3, 1968 3:00 A.M.</b>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept. 2 - 1950</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10. AGE (In years last birthday) <b>17</b>	11. BIRTHPLACE (State or foreign country) <b>PA.</b>	E. STREET AND NUMBER <b>546 Chalcot Square</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>RICHARD H. CARTER SR.</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL</b>	15. MOTHER'S MAIDEN NAME <b>MARY ROBBINS</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	17. SOCIAL SECURITY NO. <b>214-54-3825</b>	18. INFORMANT ADDRESS <b>R. H. CARTER SR 546 CHALCOT SQ.</b>	
19. CAUSE OF DEATH <b>E812.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Craneo-cerebral Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>			
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Rte. 40 and Middle River Road</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>3 31 68 2:57 A.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Roland N. Kornblum</b> M.D. EXAMINER'S NAME (Type) Roland N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-3-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/6/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sankay</b>	
25C. FUNERAL DIRECTOR <b>J. G. CONNELLY SONS</b>		25D. ADDRESS <b>300 MACE</b>	

— 11 —

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3729

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARION E. MERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 2, 1968</b> <b>6:15 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 2, 1968</b> <b>6:15 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8/23/27</b>		10. AGE (In years lost birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl S. Miller</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co</b>	
15. STREET AND NUMBER <b>5508 Oakland Road</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apprentice</b>		17. KIND OF BUSINESS OR INDUSTRY <b>Beauty Shop</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <b>No</b>		19. SOCIAL SECURITY NO. <b>216-207545</b>	
20. INFORMANT <b>Charles E. Merson</b>		ADDRESS <b>5508 Oakland Rd.</b>	
19. <b>E920.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Traumatic Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>E913.5 II</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>3920 Washington Blvd.</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4 2 68 ?</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject struck by back hoe</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Roland N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Roland N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-3-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Roland E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>Ambrose, Inc. 1328 Sulphur Sp. Rd.</b>		ADDRESS	

Paul H. K...  
[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3730

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3730

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BROWN, FREDERICK</b>		2. DATE AND HOUR OF DEATH <b>4/3/68 12<sup>50</sup> A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CALVERT Co</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN <b>PRINCE FREDERICK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-5-05</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
13. FATHER'S NAME <b>LOMIE BROWN</b>			14. MOTHER'S MAIDEN NAME <b>CORA P</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-143203</b>		17. INFORMANT <b>Rosie Brown Prince Frederick, Md.</b>	
18. <b>56211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Renal Failure &amp; Sepsis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe Perineal Abscess</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prob. Perf. Diverticulum</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>57211 II</b>					
19A. DATE OF OPERATION <b>3/29/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perineal Abscess</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Non-White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/24</b> 19 <b>68</b> to <b>4/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard N. Scott, M.D.</b>				23B. DATE SIGNED <b>4/3/68 1:00 PM</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD N. SCOTT</b>		23D. ADDRESS <b>J.H.W. Balt. Md</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>4-7-68</b>		24B. DATE <b>4-7-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Patuxent Ch. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Huntingtown Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Pinkney E. Sewell Prince Fred, Md</b>			

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1/27/74

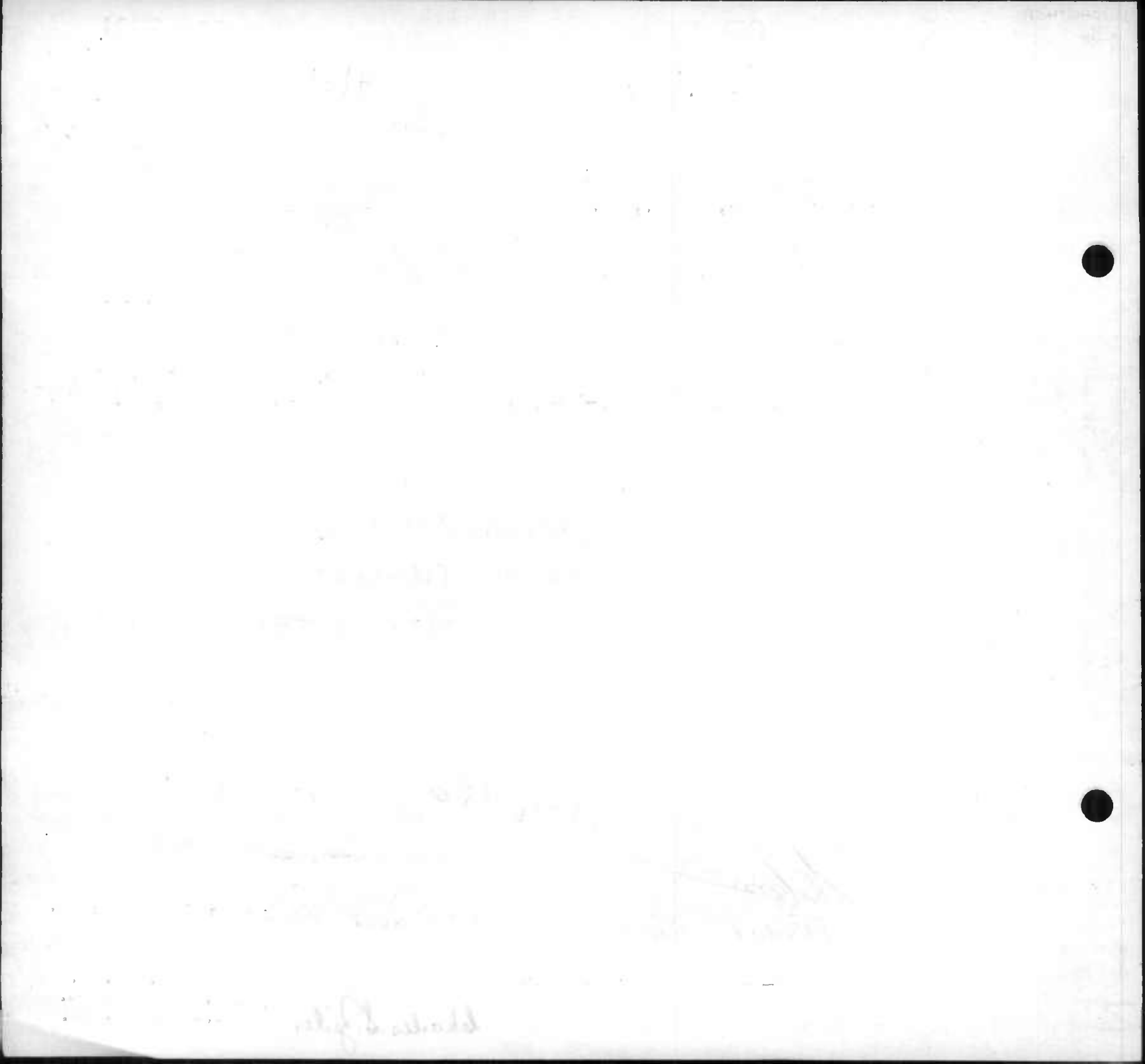
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>V-420</b>		68-3731		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>68-3731</b>	
1. NAME OF DECEASED (Type or Print) <b>JOSEPH J. ULSCH</b>				2. DATE AND HOUR OF DEATH <b>4/3/68</b> <b>9:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue, Balto., Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-01</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue, Balto., Md. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>6 South Broadway - 21231</b>							
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/18/24</b>	9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ULSCH</b>				14. MOTHER'S MAIDEN NAME <b>THERESA DOWNEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-18-2704</b>		17. INFORMANT RECORDS: <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>			
18. <b>571.01-011.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE ANEMIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CIRROSIS - MASSIVE POSTERIOR NOSE BLEED</b> <b>CHRONIC ALCOHOLISM</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 DAYS</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DELIRIUM TREMENS - OLD TBC</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME OF INJURY (APPROX.) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>4/2/68</b> 19 <b>68</b> to <b>4/3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/3/68</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Enrique Castro</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/3/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ENRIQUE CASTRO</b>				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Md.</b> <b>BALTIMORE CITY HOSPITALS 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Rd., Ba. Co., Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>		25C. FUNERAL DIRECTOR <b>Charles S. Jiles</b>		25D. ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3732

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3732

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH

KWEDAR

2. DATE AND HOUR OF DEATH

APRIL 5, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

90 HOOD NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MD.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

312 MARYDELL RD.

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

SEPT. 6, 1898

9. AGE (In years  
last birthday)

69

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

TRANSIT CO.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NOT KNOWN

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-05-9243

17. INFORMANT

William Kwedar, 167 Borden Ridge Rd.

ADDRESS

18.

250.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

A.S.C.V.D.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes Mellitus

(C)

260X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

Jan 1968

to

4/5

1968.

that (I) (we) last saw the deceased alive on

4/5

1968

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. C. Poynd

OEGREE

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

4/5/68

23C. PHYSICIAN'S  
NAME (Type)

J. C. Poynd

OEGREE

23D. ADDRESS

3325 Frederick Ave

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-8-68

24C. NAME OF CEMETERY OR CREMATORY

Landon Park Cem.

24D. LOCATION

Balto.

(City, town, or county) (State)

Ind.

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Farley Cronan B.F.H. Caterville, Ind.

ADDRESS

U.S.A.

1941

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3733

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3733

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KOPEC, EDWARD		APRIL 4, 1968 3:00A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 ST AGNES HOSPITAL		CATON & WILKENS AVENUES		MARYLAND 21225	
BALTIMORE, MARYLAND 21229		505 JEFFREY STREET		C. CITY OR TOWN D. INSIDE CITY LIMITS	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	07/28/11	56	MECHANIC
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
GENERAL ELEVATOR		MARYLAND		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH KOPEC			CATHERINE -----		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213-10-8218		CATON & WILKENS AVENUES ST AGNES HOSPITAL'S RECORDS	
18. <u>410.9 I</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<i>Acute Myocardial Infarction</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		<i>Arteriosclerotic Cardiovascular disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) -----			
19. <u>420.1 II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<i>Acute Pulmonary Edema &amp; Ventricular tachycardia</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 3 1968 to APRIL 4 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 4 1968 and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Pablo E. Dibos, M.D.</i>				23B. DATE SIGNED 04/04/68	
23C. PHYSICIAN'S NAME (Type) PABLO DIBOS, M.D.				23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-8-1968		Holy Cross Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 9 1968		<i>Robert E. Fairbanks</i>		George J. Gonce-4001 Ritchie Hwy., Baltimore	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death, shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

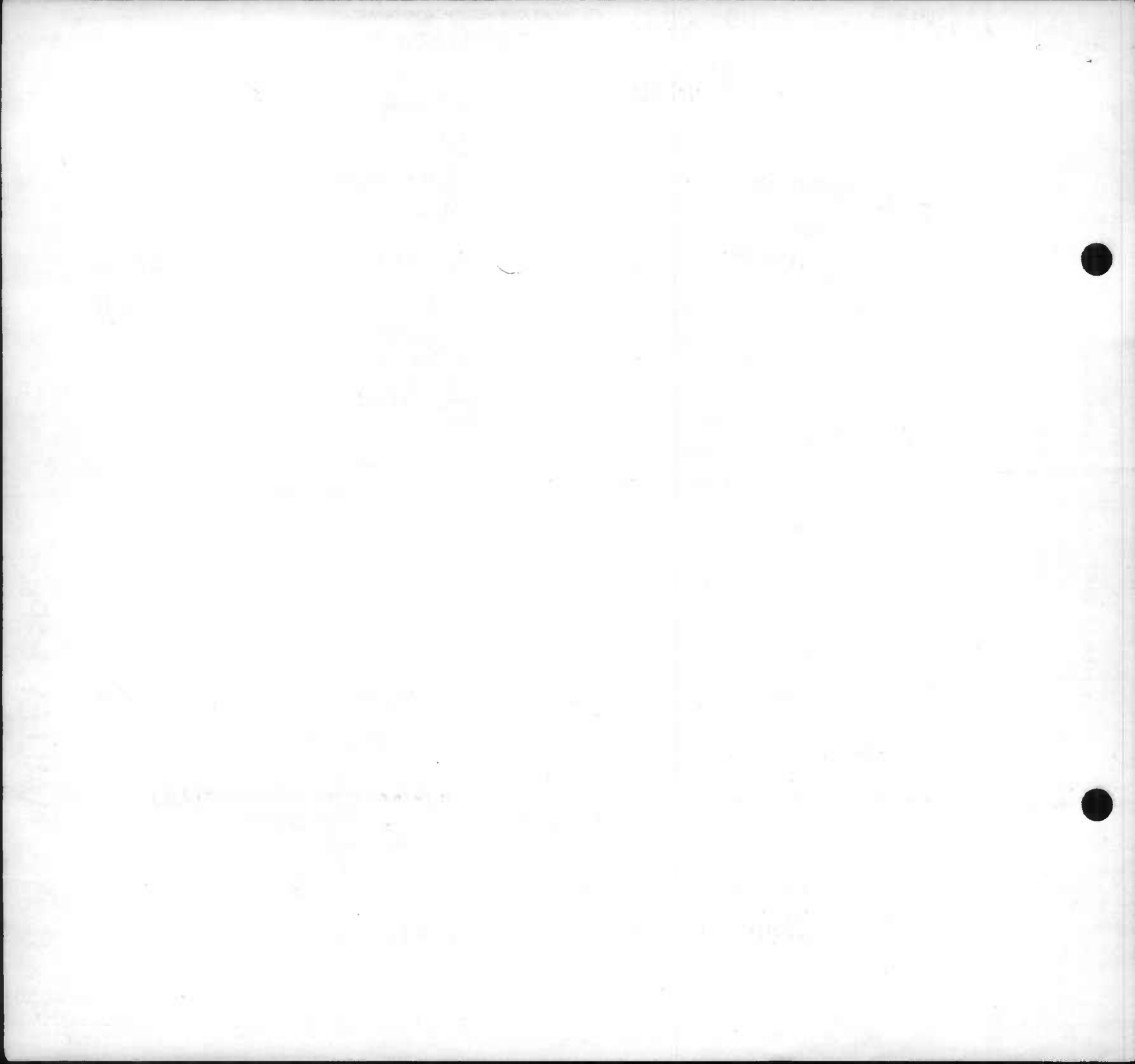
<div style="display: flex; justify-content: space-between;"> <span>D-551</span> <span>68- 3734</span> <span>68- 3734</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO.</span> </div>	
1. NAME OF DECEASED <b>BENJAMIN DANENBERG</b> <small>(Type or Print)</small>	
2. DATE AND HOUR OF DEATH <b>4/5/68</b> <span style="float: right;">1 <sup>25</sup>/<sub>PM</sub></span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE INC.</b> <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5436 PRICE AVE #15</b>	
5. SEX <b>MALE</b> 6. RACE <b>CAU</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1895</b> 9. AGE (In years lost birth) <b>73</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LEE CAP CO. CAP MAKER</b>
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH DANENBERG</b> 14. MOTHER'S MAIDEN NAME <b>ESTHER ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>XXXXXX NO</b> 16. SOCIAL SECURITY NO. <b>XXXXXX</b> 17. INFORMANT <b>MRS. ANNA K. DANENBERG</b> ADDRESS <b>5436 PRICE AVE.</b>	
18. <b>4/2/9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE <b>PNEUMONIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> (B) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>3 MONTHS</b> (C) <b>ASCVD</b> <b>6 YEARS</b>	
19. DATE OF OPERATION <b>4/2/68</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>1/19/68</b> to <b>4/5/68</b> and that <b>(W)</b> (we) last saw the deceased alive on <b>4/5/68</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(H)</b> (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Ronald Daitch M.D.</b> DEGREE <b>MD</b> 23B. DATE SIGNED <b>4/5/68</b> 23C. PHYSICIAN'S NAME (Type) <b>RONALD DAITCH, M.D.</b> DEGREE <b>MD</b> 23D. ADDRESS <b>SINAI HOSPITAL BALT.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b> 24B. DATE <b>4-7-68</b> 24C. NAME OF CEMETERY or CREMATORY <b>BETH JACOB VESHEAR</b> 24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR <b>SOL LEVINSON &amp; BROS., 6010 REISTER-</b> 25C. FUNERAL DIRECTOR ADDRESS <b>STOWN</b>	

1951

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68-3735 ✓	
BIRTH NO. M-620 68-3735				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>STEVEN J. MEYERS</b>			2. DATE AND HOUR OF DEATH <b>4/7/68 6:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL OF BALTIMORE</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>53-00</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4221 COLONIAL RD.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>3/11/68</b>	9. AGE (In years last birthday) <b>0 27</b>	If Under 1 Yr. Months: Days: Hours: Min. <b>0 27</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>MD., BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>ST RONALD MEYERS</b>			14. MOTHER'S MAIDEN NAME <b>EDITH ASHMAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>MR. RONALD MEYERS, 4221 COLONIAL ROAD</b> <del>XXXXXXXXXX</del> <del>XXXXXXXXXX</del>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>INTERVENTRICULAR HEMORRHAGE</b> DUE TO <b>?</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>760.0 II</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 HRS. ?</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/4/68</b> 19 to <b>4/7/68</b> 19, that (I) (we) last saw the deceased alive on <b>4/7/68</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alan H. Mitnick</b> M.D.				23B. DATE SIGNED <b>4/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN H. MITNICK</b> M.D.			23D. ADDRESS <b>SINAI HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-8-68</b>		24C. NAME of CEMETERY or CREMATORY <b>MOSES MONTIFORE</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

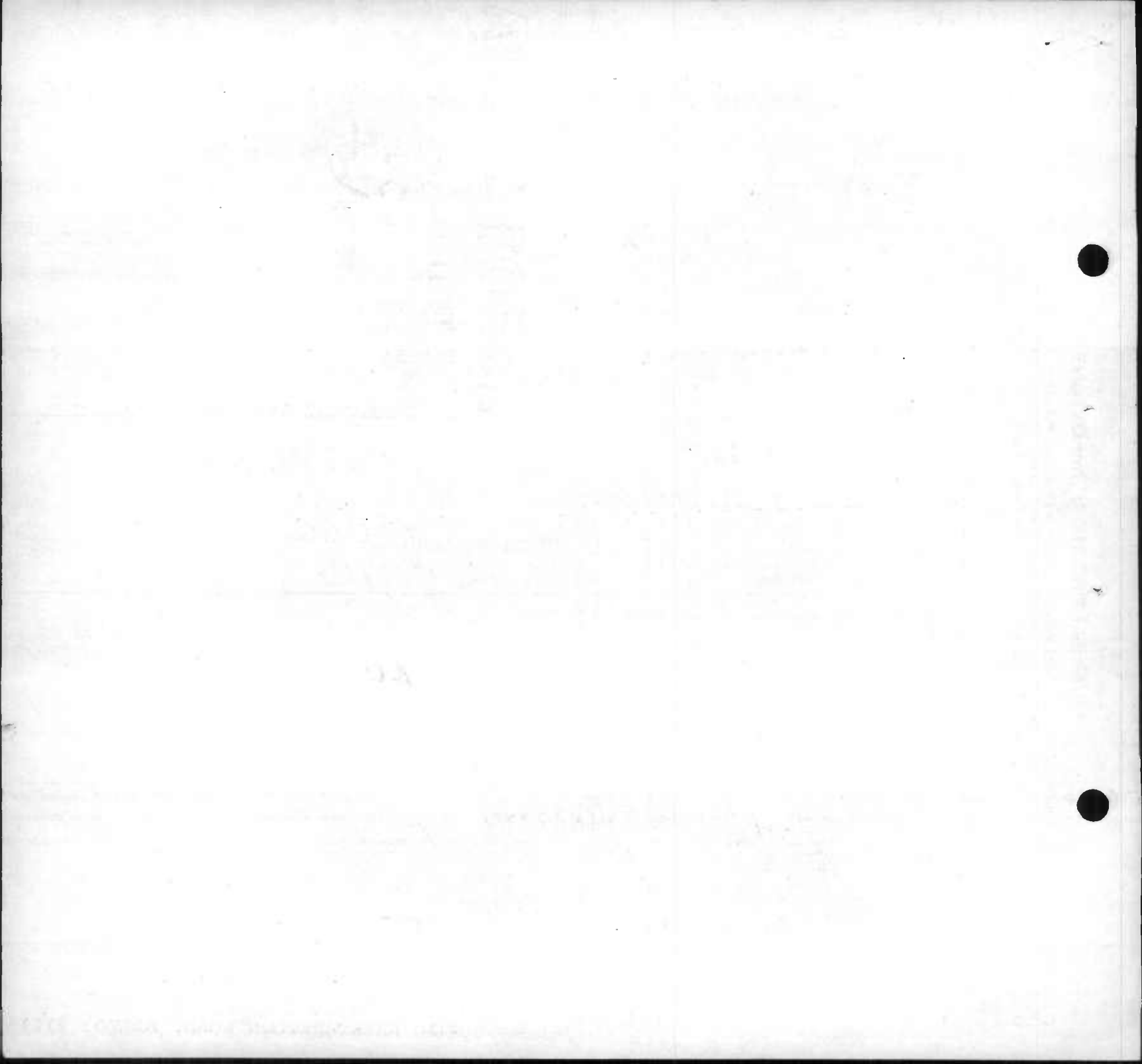
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68-3736				68-3736	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Elizabeth C. Martin			4-1-68 2:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Mercy Hospital			Md. 5-02		
5. SEX			6. DATE OF BIRTH		7. AGE (In years lost birthday)
F			3-25-09		58
6. RACE			7. MARRIED		NEVER MARRIED
W			WIDOWED		DIVORCED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Hwy					PENNA.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Bryns			Julia Kels		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Respiratory arrest		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Pulmonary metastatic lesions		
			(C) Adenocarcinoma of the uterus, metastatic		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
174X II					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from March 6, 1968 to April 1, 1968 1968 that (I) (we) last saw the deceased alive on April 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ophelia G. Loot				April 3, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ophelia Loot				Mercy Hospital	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
APR 3 1968				ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 9 1968		Robert E. Taylor		UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

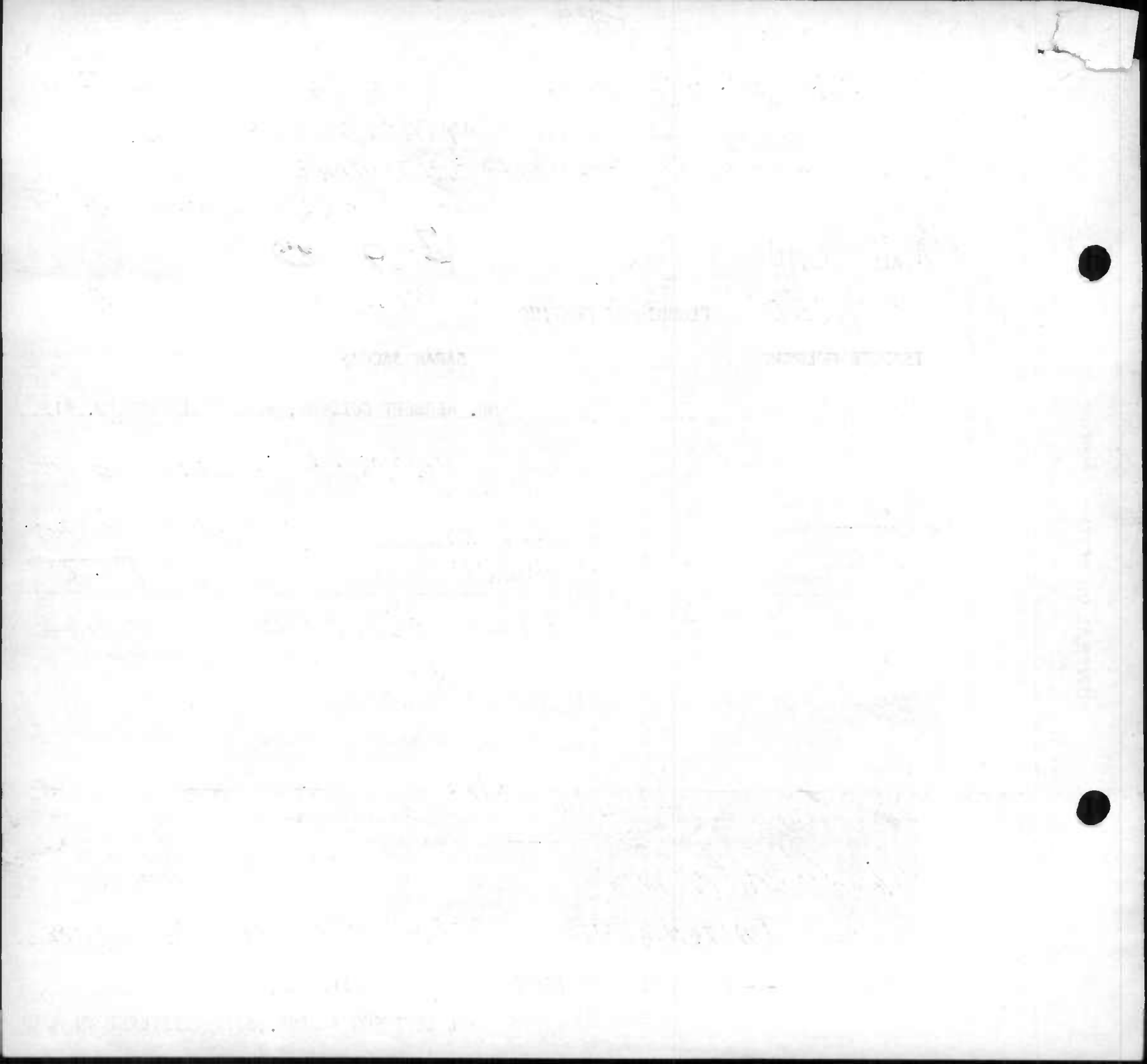
BALTIMORE CITY HEALTH DEPARTMENT										
68- 3737					REG. NO. 68- 3737					
<div style="display: flex; justify-content: space-between;"> <div> <p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <i>Irving Winegrad</i></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <i>4/5/68 10:55 P.M.</i></p> </div> </div>										
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>					<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTO</i></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>2905 FALLSTAFF ROAD #21215</i></p>					
<p>5. SEX <i>MALE</i></p>		<p>6. RACE <i>WHITE</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>JULY 26, 1903</i></p>		<p>9. AGE (In years last birthday) <i>64</i></p>		
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PROPRIETOR</i></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY <i>RESTAURANT</i></p>			<p>11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>		
<p>13. FATHER'S NAME <i>MARTIN WILLIAM WINEGRAD</i></p>					<p>14. MOTHER'S MAIDEN NAME <i>ESTHER ?</i></p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i></p>			<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS <i>MRS. DOLORES WINEGRAD, 2905 FALLSTAFF</i></p>					
<p>18. <i>4/2/68</i> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arrhythmia 2nd degree block</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Renal failure</i></p> <p>(C) <i>ASCVD</i></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <i>422.1 II</i></p>										
<p>19A. DATE OF OPERATION <i>4/5/68</i></p>			<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>			<p>20A. AUTOPSY? (Yes or No) <i>NO</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>			<p>21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)</p>			<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>				
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>			<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>			<p>21F. HOW DID INJURY OCCUR?</p>				
<p>22. I certify that (I) (this hospital) attended the deceased from <i>4/5/68</i> to <i>4/5/68</i> that (I) (we) last saw the deceased alive on <i>10/5/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</p>										
<p>23A. SIGNATURE <i>A. S. Glushakow</i></p>					<p>23B. DATE SIGNED</p>			<p>23C. PHYSICIAN'S NAME (Type) <i>A. S. GLUSHAKOW</i></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i></p>					<p>24B. DATE <i>4-7-68</i></p>		<p>24C. NAME of CEMETERY or CREMATORY <i>BNAI ISRAEL</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p>			<p>25B. NAME OF REGISTRAR</p>			<p>25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN ROAD, BALTO. 21215</i></p>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-3738	
BIRTH NO. 6-435 68-3738				1. NAME OF DECEASED (Type or Print) JACOB J. GOLDMAN		2. DATE AND HOUR OF DEATH 4/3/68 12:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3601 CLARKS LANE #15				5. SEX MALE 6. RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY PLUMBING & HEATING		8. DATE OF BIRTH 12/2/89 9. AGE (In years last birthday) 78	
13. FATHER'S NAME ISADORE GOLDMAN				14. MOTHER'S MAIDEN NAME SARAH JACOBS		11. BIRTHPLACE (State or foreign country) POLAND 12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. HERBERT GOLDMAN, 3206 FALLSTAFF RD. #15	
18. 4-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE MYOCARDIAL FAILURE		6 DAYS	
ANTECEDENT CAUSES				(B) MYOCARDIAL INFARCTION		6 DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) ASCVD		1 YEAR	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				RENAL FAILURE		6 DAYS	
19A. DATE OF OPERATION 4-20-1				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/28 1968 to 4/3 1968, that (we) last saw the deceased alive on 4/3 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				23A. SIGNATURE Ronald Daitch, MD		23B. DATE SIGNED 4/3/68	
23C. PHYSICIAN'S NAME (Type) RONALD DAITCH, MD				23D. ADDRESS SINAI HOSPITAL BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 4-4-68 24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW 24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968				25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



5-26/1

68- 3739

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3739

BIRTH NO.

1. NAME OF DECEASED

SEGRAVES BANNER C.

2. DATE AND HOUR OF DEATH

APRIL 3, 1968 2:45A.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

ST AGNES HOSPITAL

FULL NAME OF INSTITUTION, GIVE STREET

WILKENS AND CATON AVENUE  
BALTIMORE MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

MARYLAND 21229

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4900 PARKTON COURT

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

01/20/85

9. AGE (In years  
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

COLUMBUS F. SEGRAVES

14. MOTHER'S MAIDEN NAME

(BLEVINS) SEGRAVES SAMATHA

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ST AGNES HOSPITAL WILKENS &amp; CATON AVE

18. 204.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Bilateral Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Chronic Lymphocytic Leukemia

(C)

204.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

ASCVD - Parkinson's Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from FEBRUARY 22 1968 to APRIL 3 1968,  
that ☒ (we) last saw the deceased alive on APRIL 3 1968 and that in ☒ (our) opinion death occurred on the date  
and hour and from the causes stated above. ☒ (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-3-68

23C. PHYSICIAN'S  
NAME (Type)

E.H. Weiss, M.D.

DEGREE

23D. ADDRESS

ST AGNES HOSPITAL WILKENS &amp; CATON AVE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4/5/68

24C. NAME OF CEMETERY or CREMATORY

Woodlawn

24D. LOCATION

(City, town, or county)

BALTO

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

E S Mac Nabbs

ADDRESS

Catonville Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

WYLLAND

PAULINORE

1802 240 112

DIASCO

NORTH CAROLINA

SALE (SING) 1000

ST ADAMS HOSPITAL

1000-1000

1000-1000

1000-1000

CHIEF

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

1000-1000

FUNERAL DIRECTOR: IMPORTANT

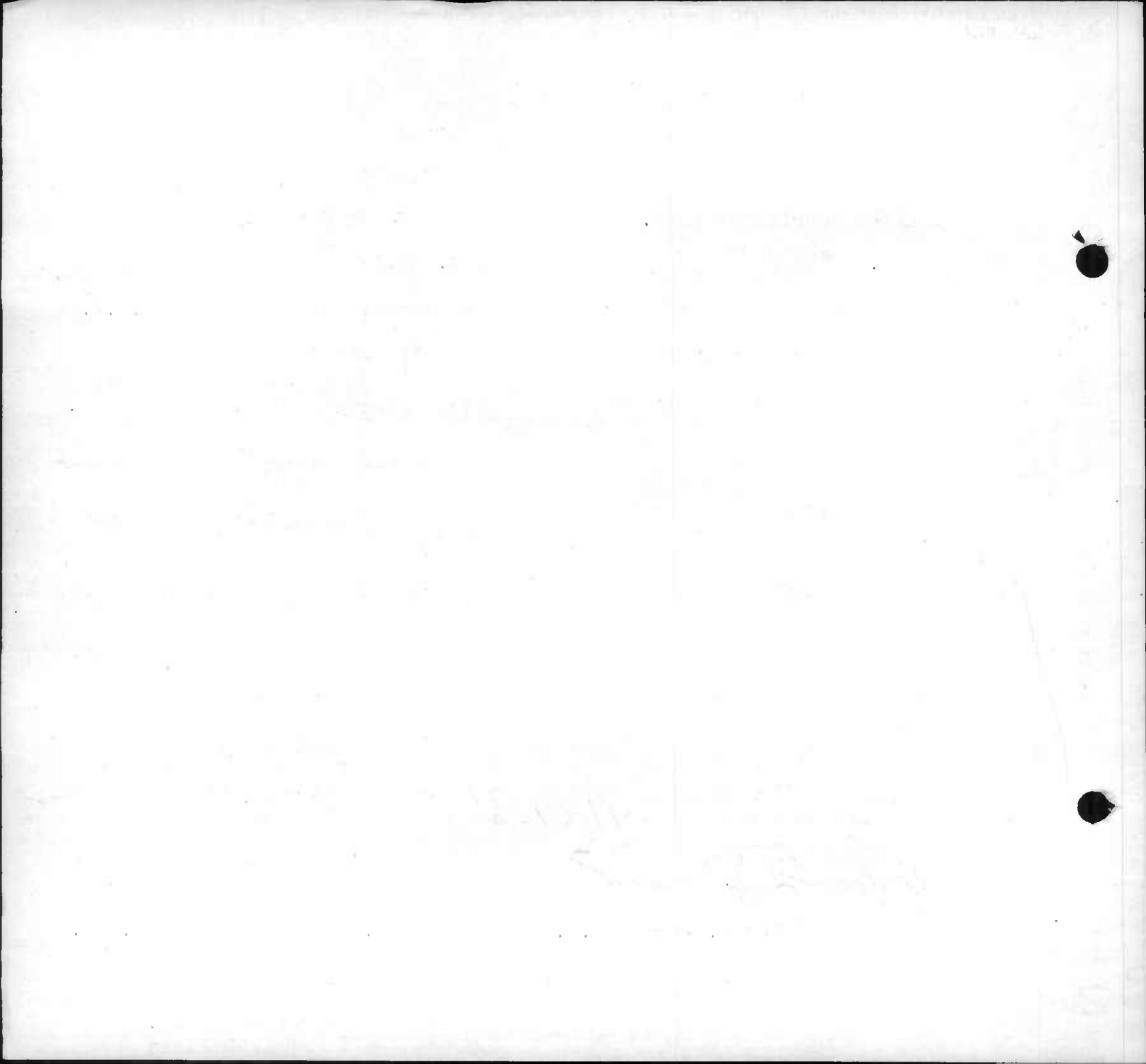
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3740

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3740

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JANE MC ILVAIN SCOTT		APRIL 3, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
00 The Warrington Apts.				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3908 North Charles Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 28, 1878	89	Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		At Home		Baltimore, Maryland	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Alexander McIlvain			Elizabeth Armstrong Anderson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		216 07 7946		3908 North Charles Street Miss Dorothy McIlvain Scott	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Ischemic heart dis. 3 wks	
				(B) Coronary sclerosis	
				(C) —	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/18 1968 to 4/3 1968, that (I) (we) last saw the deceased alive on 4/3/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William F. Renner				23B. DATE SIGNED 4/4/68	
23C. PHYSICIAN'S NAME (Type) William F. Renner M.D.				23D. ADDRESS 3222 St. Paul Street Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/5/68		Greenmount Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		25A. DATE REC'D BY HEALTH DEPT.	
Baltimore Maryland				25B. NAME OF REGISTRAR	
		25C. FUNERAL DIRECTOR		25D. ADDRESS	
		HENRY SANDER & SONS INC.		BALTIMORE MARYLAND 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

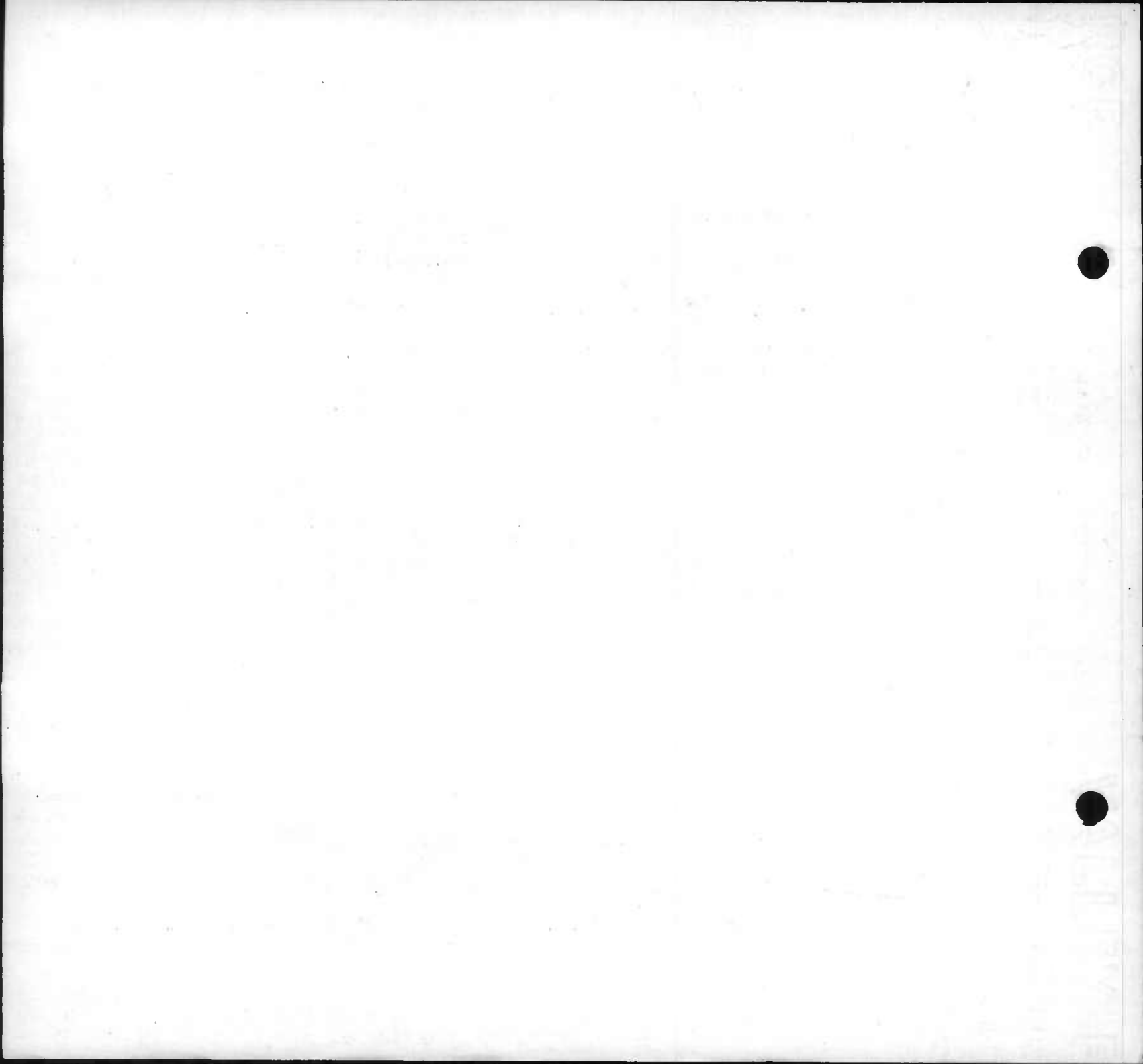
68- 3741

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3741

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ADAM VINCENT KOLB		APRIL 2, 1968 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND	
00 1515 Tunlaw Road				C. CITY OR TOWN BALTIMORE 21218	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1515 Tunlaw Road	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1895	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Fireman Balto. City Fire Dept. Retired		Baltimore Md.		USA	
13. FATHER'S NAME William Nicholas Kolb			14. MOTHER'S MAIDEN NAME Mary T. Hogan Kolb		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		46 0946		Mrs Marie A. Kolb 1515 Tunlaw Road	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				1. hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				2 yrs	
331 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/24/66 to 4/2/68, that (I) (we) last saw the deceased alive on 4/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Conrad Richter M.D.				23B. DATE SIGNED April 4, 1968	
23C. PHYSICIAN'S NAME (Type) Conrad Richter M.D.				23D. ADDRESS 3128 Harford Road, Balto. Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/5/68		Moreland Memorial Park	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 9 1968		Robert E. Farber		HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213	



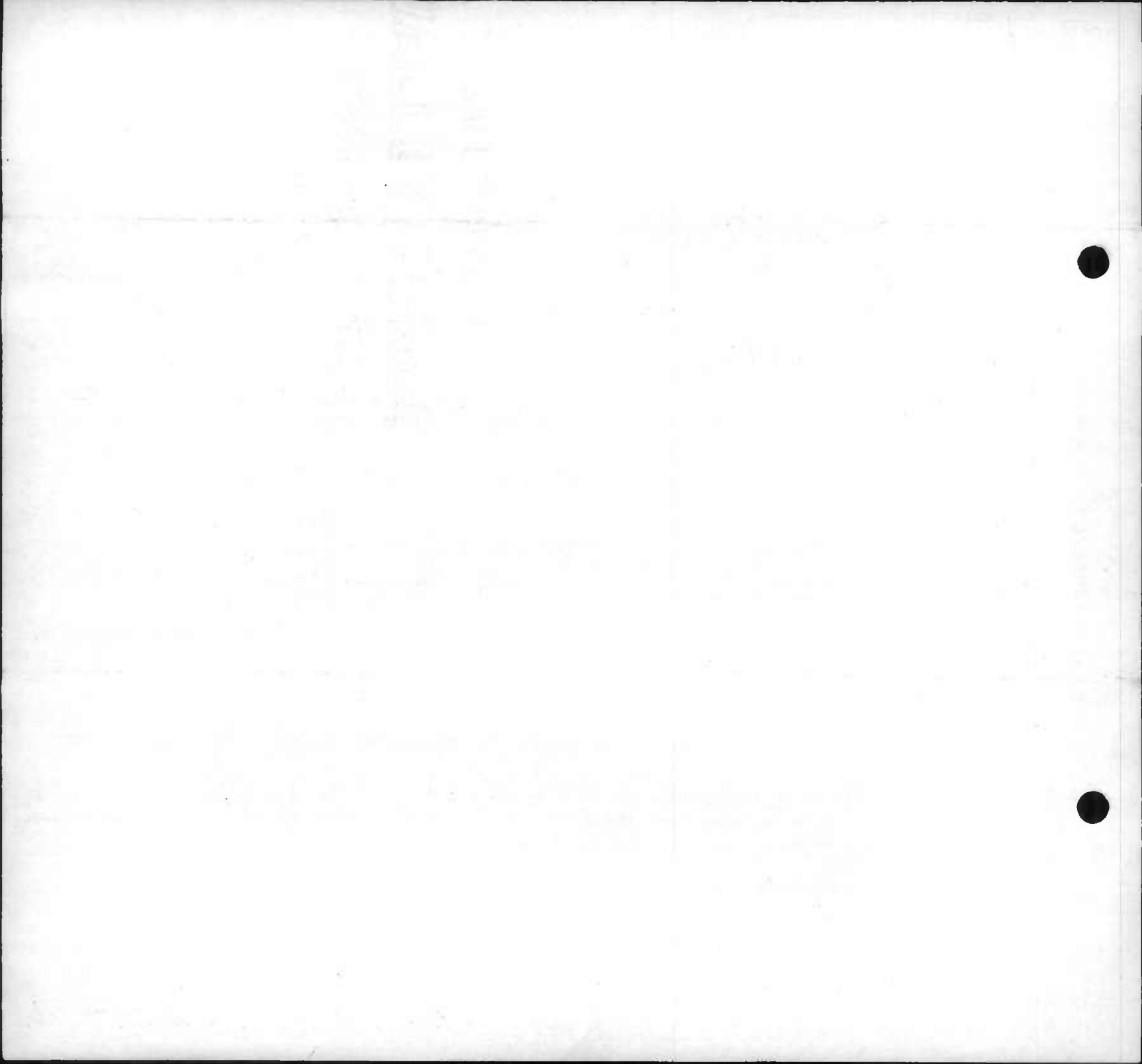
**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3742 CERTIFICATE OF DEATH

REG. NO. 68- 3742

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Anna E. Blair</u>		2. DATE AND HOUR OF DEATH <u>April 4 1968</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-01</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11/9/07</u>		9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jerome Golibart</u>	
14. MOTHER'S MAIDEN NAME <u>Harker</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-30-4902</u>	
17. INFORMANT <u>Mrs Davis Hyatt - 4 Osborne Ave.</u>		ADDRESS			
18. CAUSE OF DEATH <u>420.1 II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u>			<u>hours</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congestive heart failure</u>			<u>days</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary sclerosis</u>			<u>years</u>		
(C) <u>myocardial disease</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-29-</u> <u>1968</u> to <u>4-4-</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>4-4-</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hashemi M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M-J. HASHEMI M.D.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-8-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Family Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Harrisonville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>	
25C. FUNERAL DIRECTOR <u>Swley-Cranney Bldg - Citonville Md.</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

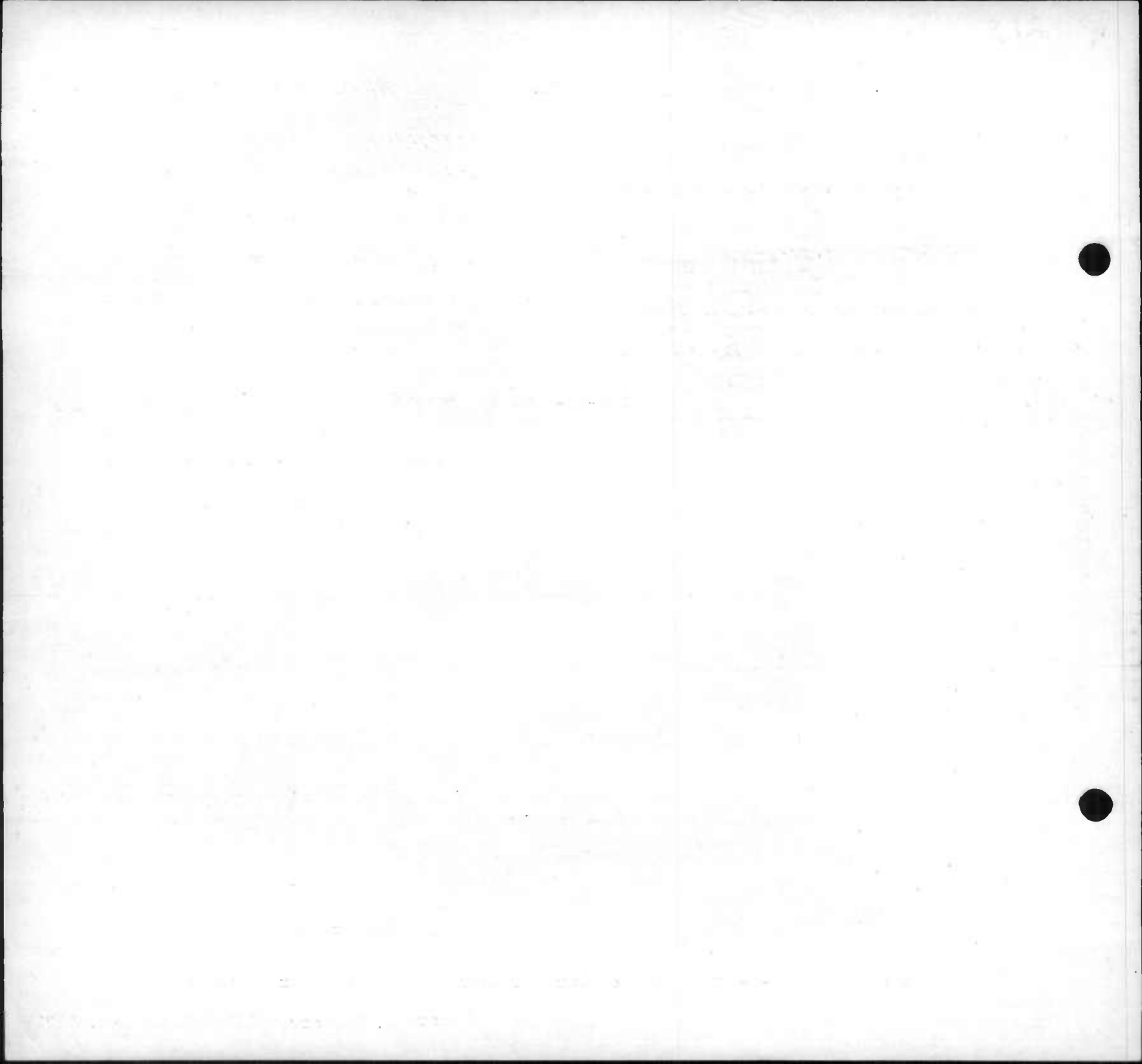
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3743

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3743

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DOBYSKI MA. EDWARD L, Sr.</b>		2. DATE AND HOUR OF DEATH <b>APRIL 5<sup>th</sup> 940 AM 1968</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>MARYLAND</b> CITY <b>CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1928 CHRISTIAN ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-13</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTOMOBILE MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BURKE SAVAGE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
13. FATHER'S NAME <b>ANTHONY DOBYSKI</b>			14. MOTHER'S MAIDEN NAME <b>F</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-6694</b>		17. INFORMANT ADDRESS <b>WIFE 1928 CHRISTIAN ST. BALTIMORE, MD</b>	
18. <b>93.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac arrest due to uremia</b> days (B) <b>Uremia</b> days (C) <b>Kidney dysfunction</b> weeks ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION <b>603X II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/17/1968</b> to <b>4-5-1968</b> , that (I) (we) last saw the deceased alive on <b>4-5-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Hashemi</b> DEGREE				23B. DATE SIGNED <b>4/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. J. Hashemi</b> DEGREE				23D. ADDRESS <b>Bon Secour Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-9-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



K-450

68- 3744 BALTIMORE CITY HEALTH DEPARTMENT

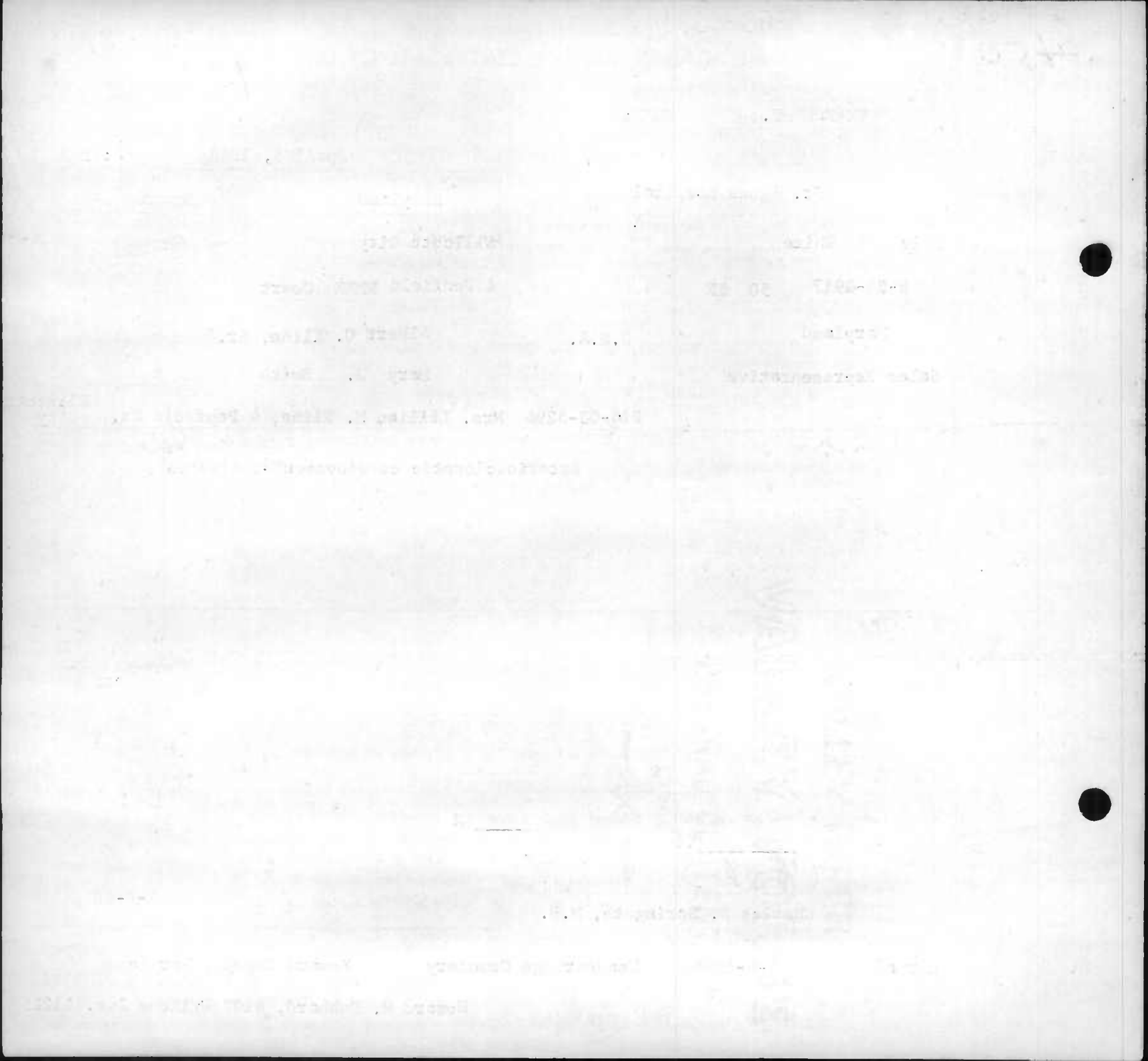
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3744

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>VERNON F. KLINE</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 8:05 A</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard</b> <b>63-00</b>				C. CITY OR TOWN <b>Ellicott City</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>4 Penfield Road Court</b>	
9. DATE OF BIRTH <b>8-24-1917</b>		10. AGE (In years lost birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Representative</b>				13. FATHER'S NAME <b>Albert C. Kline, Sr.</b>		15. MOTHER'S MAIDEN NAME <b>Mary J. Smith</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. <b>216-03-5296</b>		18. INFORMANT ADDRESS <b>Mrs. Lillian M. Kline, 4 Penfield Ct., City Ellicott</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-6-68</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-9-1968</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



**FUNERAL DIRECTOR: IMPORTANT**

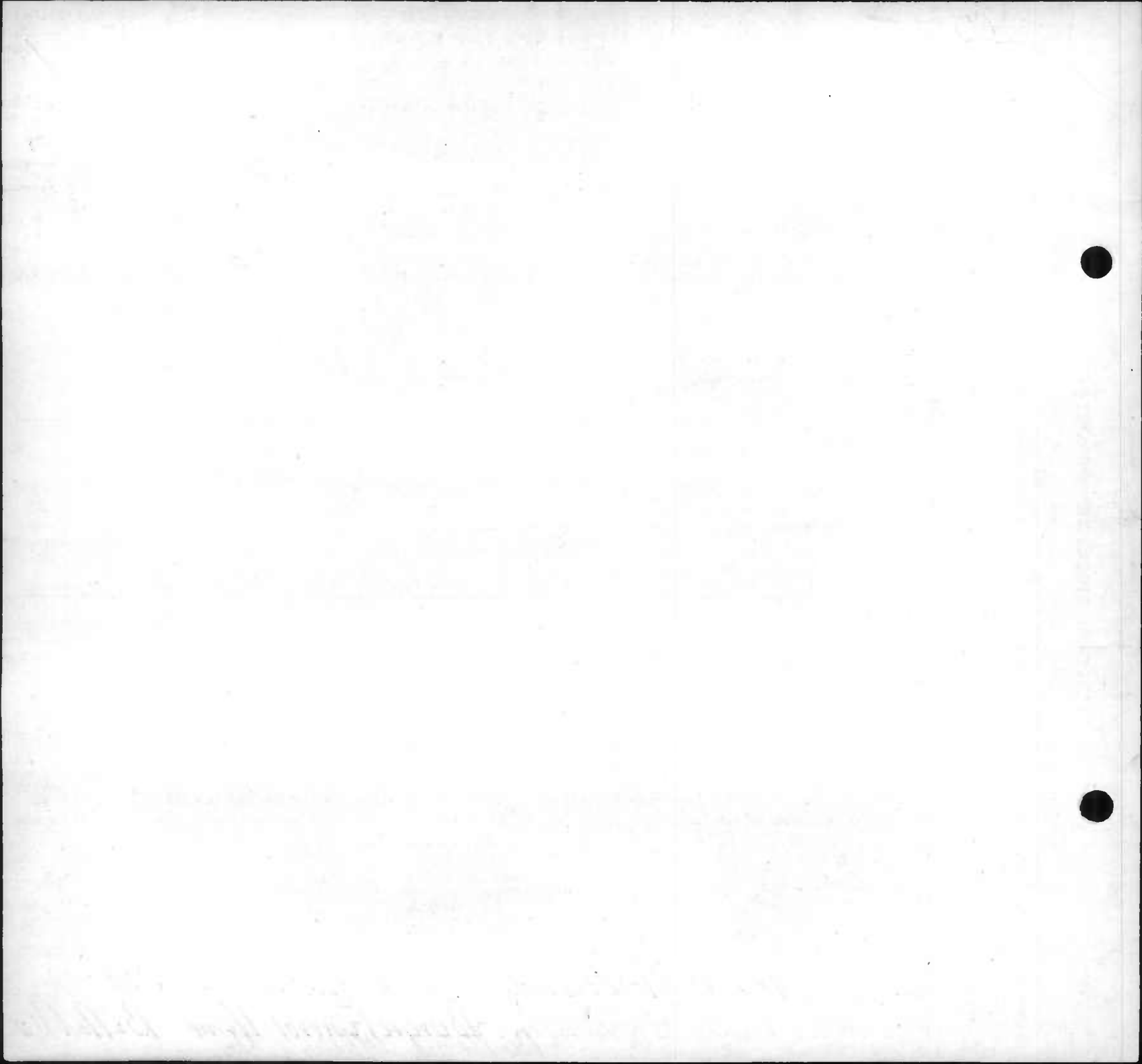
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3745

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3745

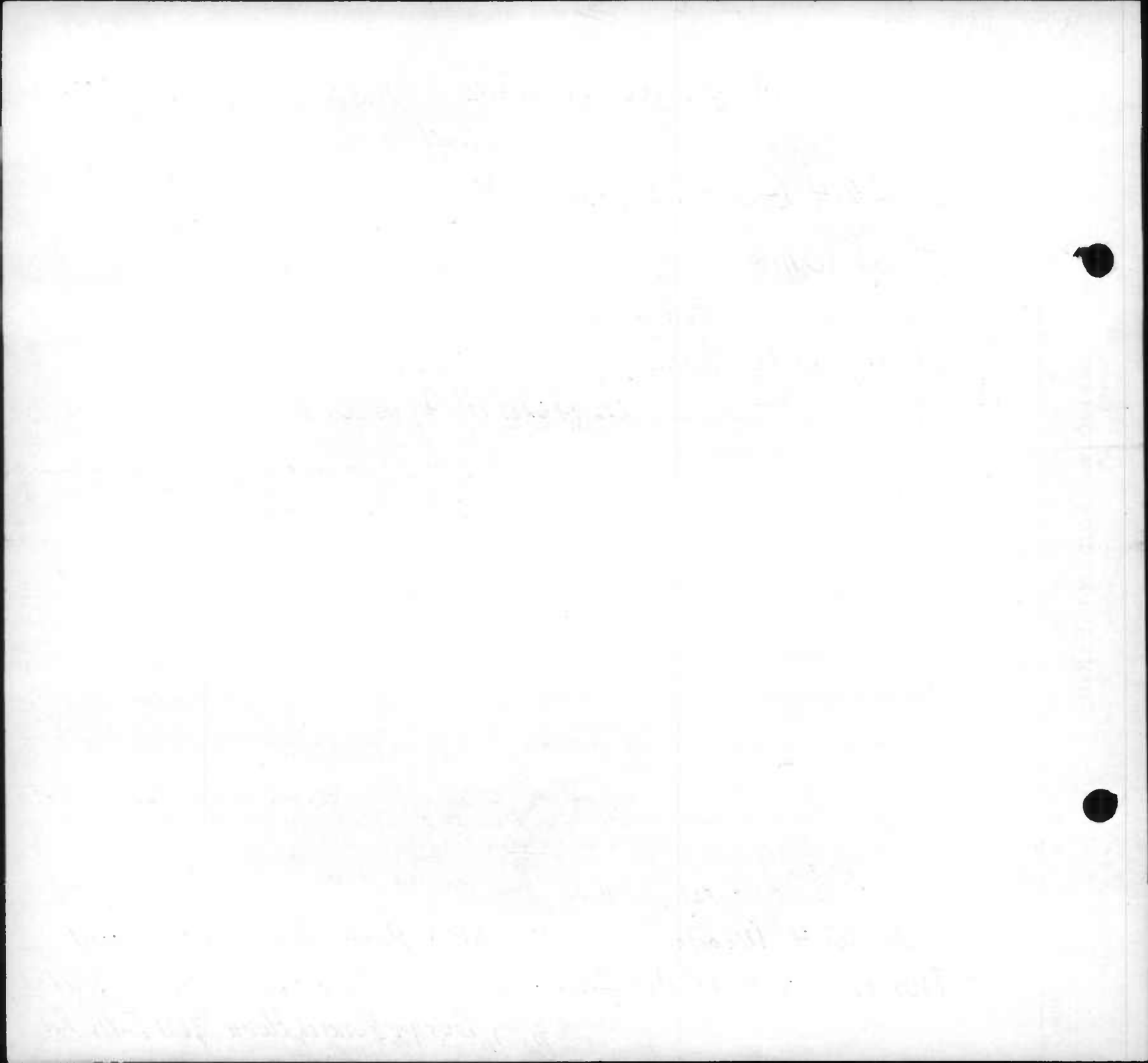
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LEOLA M PENNELL</b>		2. DATE AND HOUR OF DEATH <b>3-31-1968 1.45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MONTEBELLO STATE Hospital</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3534 West 1927 St PAUL ST</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-25-04</b>	9. AGE (In years last birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>CHARLES KEARNEY</b>		14. MOTHER'S MAIDEN NAME <b>ELLA MAY VIESE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-0933</b>		17. INFORMANT ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Myocardial infarction</b> <b>Myocardial infarction</b> <b>ASCVD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21 1967</b> to <b>March 31 1968</b> , that (I) (we) last saw the deceased alive on <b>3-31-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert Folgueras M.D.</b>				23B. DATE SIGNED <b>3-31-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALBERT FOLGUERAS</b>				23D. ADDRESS <b>Montebello State Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem Ph Howard Co Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Burgess General Home Bldg Md</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 3746				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3746			
1. NAME OF DECEASED (Type or Print) <b>M. GRACE WILLIAMS</b>				2. DATE AND HOUR OF DEATH <b>MARCH 31 1968 10:30 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO.</b>				C. CITY OR TOWN <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>2614 Guilford Ave</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>2614 Guilford Ave</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 11 1883</b>		9. AGE (In years last birthday) <b>85</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Fed. Land Bank</b>				11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry B Williams</b>				14. MOTHER'S MAIDEN NAME <b>Annie L Bond</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220 44 6268</b>		17. INFORMANT <b>M. Agnes Williams</b>				ADDRESS <b>2614 Guilford Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.1 II</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Conjunctive Heart Failure Myocardial infarction Sclerotic arterio-sclerosis aortic</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1930</b> to <b>March 31 1968</b> , that (I) (we) lost saw the deceased alive on <b>March 30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>M. H. Woody</b>				23B. DATE SIGNED <b>4-3-69</b>							
23C. PHYSICIAN'S NAME (Type) <b>Dr. W. H. Woody</b>				23D. ADDRESS <b>1403 Park Ave BALTO MD</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-4-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT Zion Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Freeland, BALTO Co, MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>		ADDRESS <b>3631 Falls Rd</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3747

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3747

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Alice A. Koch</i>		2. DATE AND HOUR OF DEATH <i>4-5-68 2:05 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>#21230</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>109 W. Randall St.</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-13-96</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Geo. Nicky</i>		14. MOTHER'S/MAIDEN NAME <i>Mary E. Fredericks</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Same</i> ADDRESS	
18. <i>427.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Accident, probably Embolus</i> (B) <i>Actual Fibrillation and Atrial Fibrillation</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <i>April 5</i> 19 <i>68</i> to <i>April 5</i> 19 <i>68</i> , that <del>at</del> (we) last saw the deceased alive on <i>April 5</i> 19 <i>68</i> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Colvin C. Carter, M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-5-68.</i>	
23C. PHYSICIAN'S NAME (Type) <i>Colvin C. Carter, M.D.</i>		23D. ADDRESS <i>1213 Light St.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		24B. DATE <i>4/9/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>	
24D. LOCATION (City, town, or county) <i>Balto</i>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>McQuay - 130 E. Foul St.</i> ADDRESS	

South Atlantic General Corp.  
White  
7-13-38

Colon G. Carter, MD 1913 Right 24

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3748

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE DONNELL</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 9:25 A.</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Korean</b>		17. SOCIAL SECURITY NO. <b>238-34-3660</b>	
15. MOTHER'S MAIDEN NAME <b>Louise Giles</b>		18. INFORMANT <b>Raymond Donnell, same</b>	
19. <b>430.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive subarachnoid hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>4/30/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Greensboro</b>		24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MA</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

WALLEY POINT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3749

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3749

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KOENIG GEORGE H. SR.

2. DATE AND HOUR OF DEATH

4-4-68

7:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

321 S. Norris St

5. SEX

MALE

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7-29-11

9. AGE (In years lost birthday)

56

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Disability

10B. KIND OF BUSINESS OR INDUSTRY

machinist

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Koenig

14. MOTHER'S MAIDEN NAME

Mary Smith

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

(If yes, give war or dates of service)

Yes

World War II

16. SOCIAL SECURITY NO.

212-12-9130

17. INFORMANT

ADDRESS

Ida May Koenig 321 S. Norris Street

18.

162-1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

(B) RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF:

CA of the Lung, PNEUMONIA

163X II

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1 19 68 to April 4 19 68, that (I) (we) last saw the deceased alive on April 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Adrian V. Villarin MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

April 4, 1968

23C. PHYSICIAN'S NAME (Type)

ADRIAN V. VILLARIN MD

DEGREE

23D. ADDRESS

Bon Secours Hospital

Md

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/8/68

24C. NAME OF CEMETERY or CREMATORY

Balto. National Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

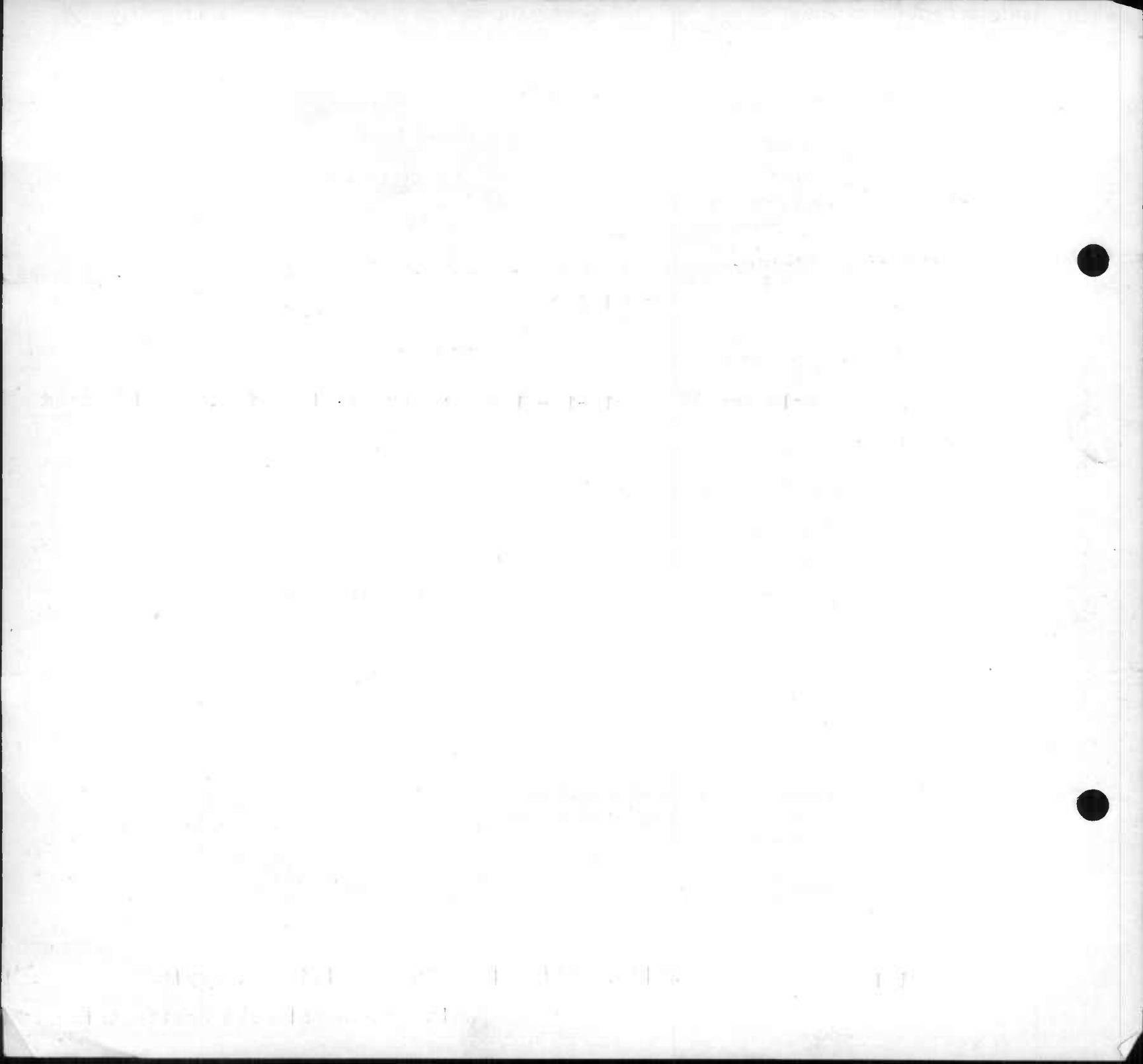
25C. FUNERAL DIRECTOR

ADDRESS

APR 9 1968

Walters Funeral Home Pratt & Stricker

8ts.



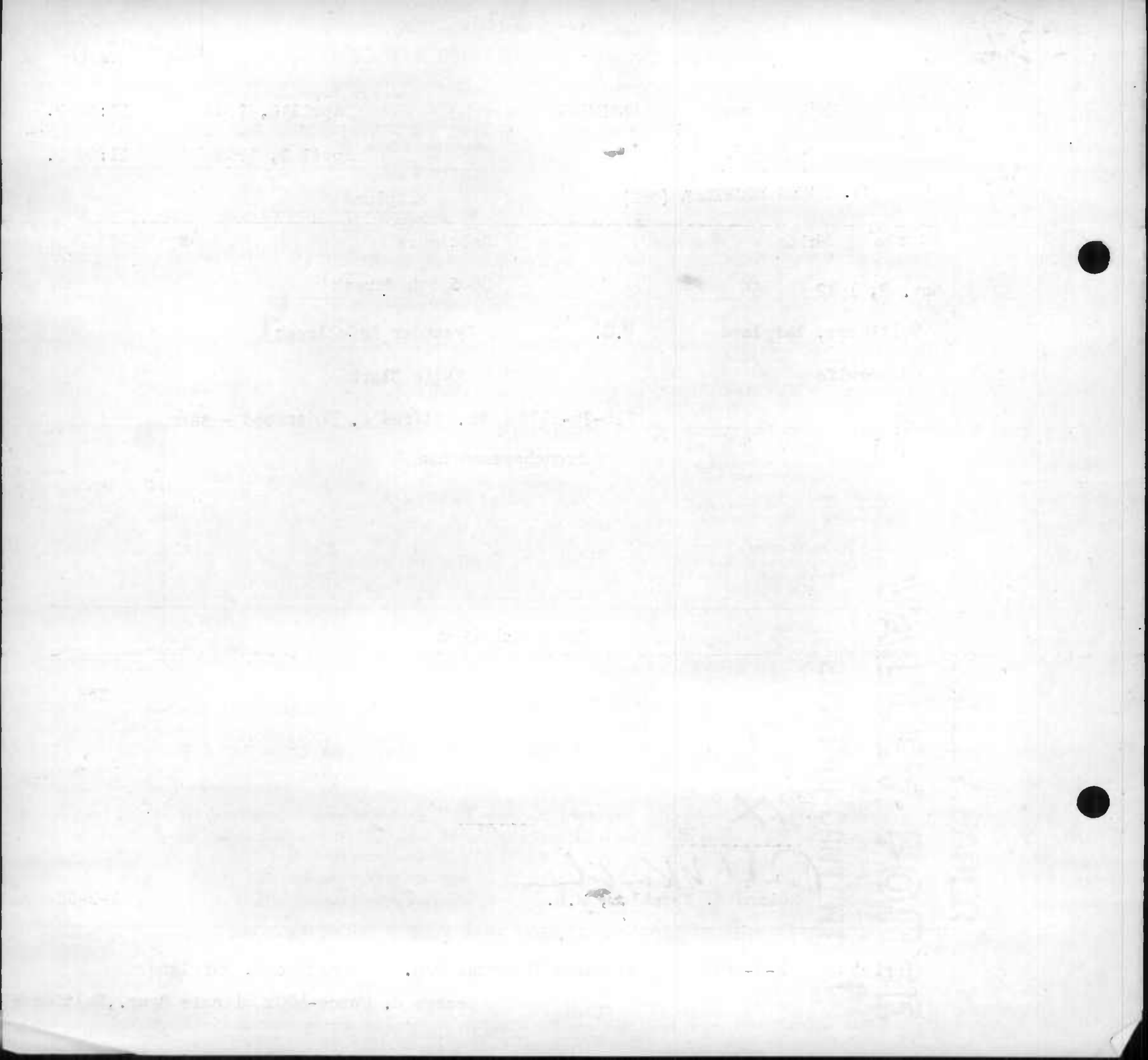
U-536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3750

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>INEZ Mae UNDERWOOD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 2, 1968</b> 11:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 2, 1968</b> 11:20 P.M.	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>Nov. 2, 1912</b>		10. AGE (in years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-26-2178</b>	
18. INFORMANT <b>Mr. Alfred J. Underwood - same</b>		ADDRESS	
19. <b>485 X 1 + 303.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Roland N. Kornblum, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-3-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 68- 3751 CERTIFICATE OF DEATH

REG. NO.

68- 3751

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

REYNOLDS, Francis Patrick, Jr.

2. DATE AND HOUR OF DEATH

4/5/68

4:59 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Veterans Administration Hospital  
3900 Loch Raven Boulevard  
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland 21085

C. CITY OR TOWN

Joppa

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

531 Trimble Road

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6/10/14

9. AGE (In years  
last birthday)

53

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Photo Mach Opr.

10B. KIND OF BUSINESS OR INDUSTRY

St. of Md.  
Retired

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis P Reynolds Sr.

14. MOTHER'S MAIDEN NAME

Jennie Bracken

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

Yes

(If yes, give war or dates of service)

3/2/44 - 5/7/46

16. SOCIAL  
SECURITY NO.

216-03-7721

17. INFORMANT

VA Hospital Records

ADDRESS

3900 Loch Raven Boulevard, Baltimore, Md 21218

18.

4918 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Chronic Bronchitis

10 years +

DUE TO, OR AS A CONSEQUENCE OF:

(B) Chronic obstructive Pulmonary Emphysema

10 years +

(C) Chronic Cor Pulmonale

10 years +

MEDICAL CERTIFICATION

502.0 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from March 13th 19 68 to April 5th 19 68,  
that (1) (we) last saw the deceased alive on April 5th 19 68 and that in (1) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.

23A. SIGNATURE

Richard A. Anderson

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

April 5, 1968

23C. PHYSICIAN'S  
NAME (Type)

RICHARD A. ANDERSON M.D.

DEGREE

23D. ADDRESS

3900 Loch Raven Boulevard  
Baltimore, Maryland 2121824A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/8/68

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

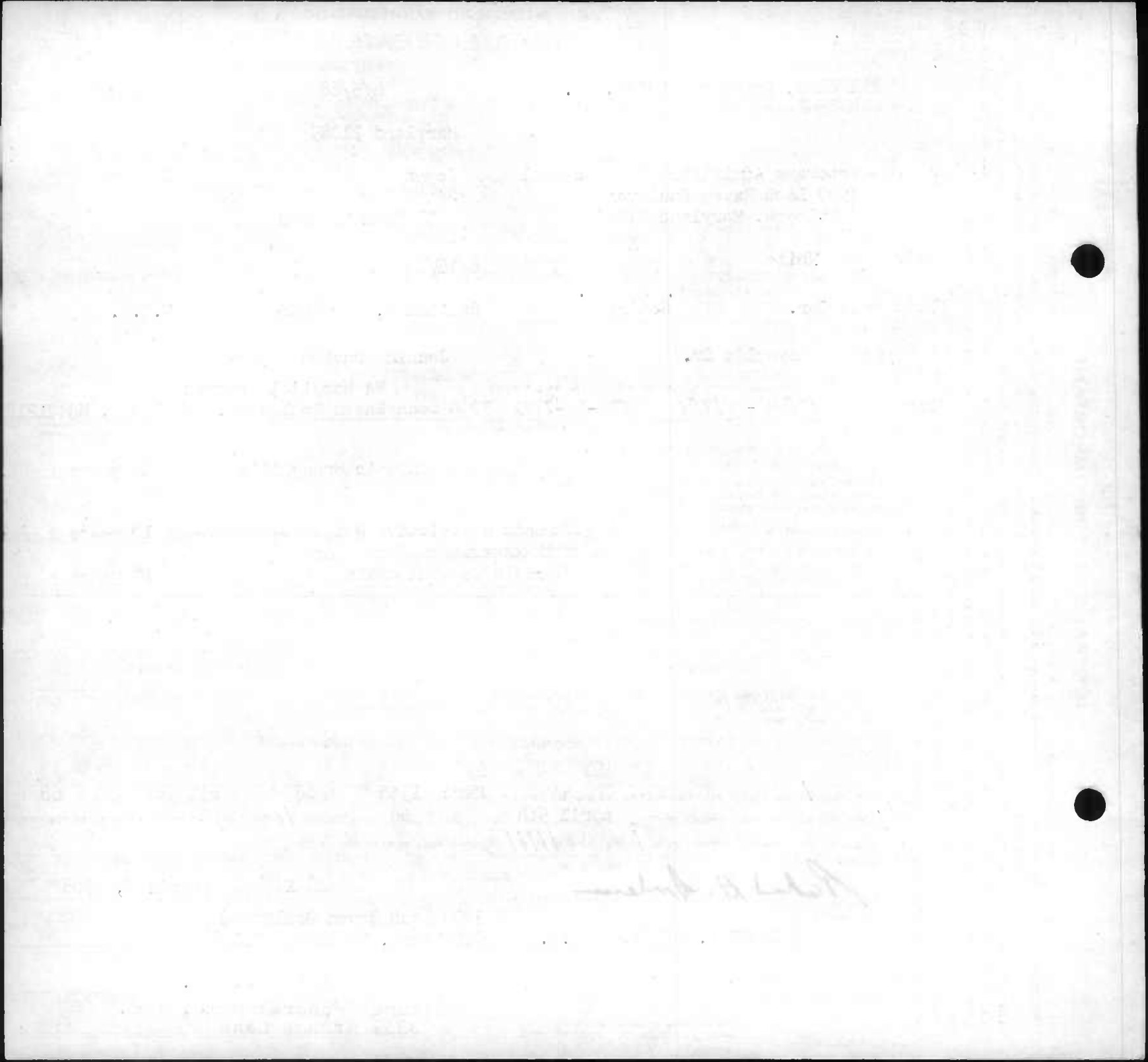
25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS



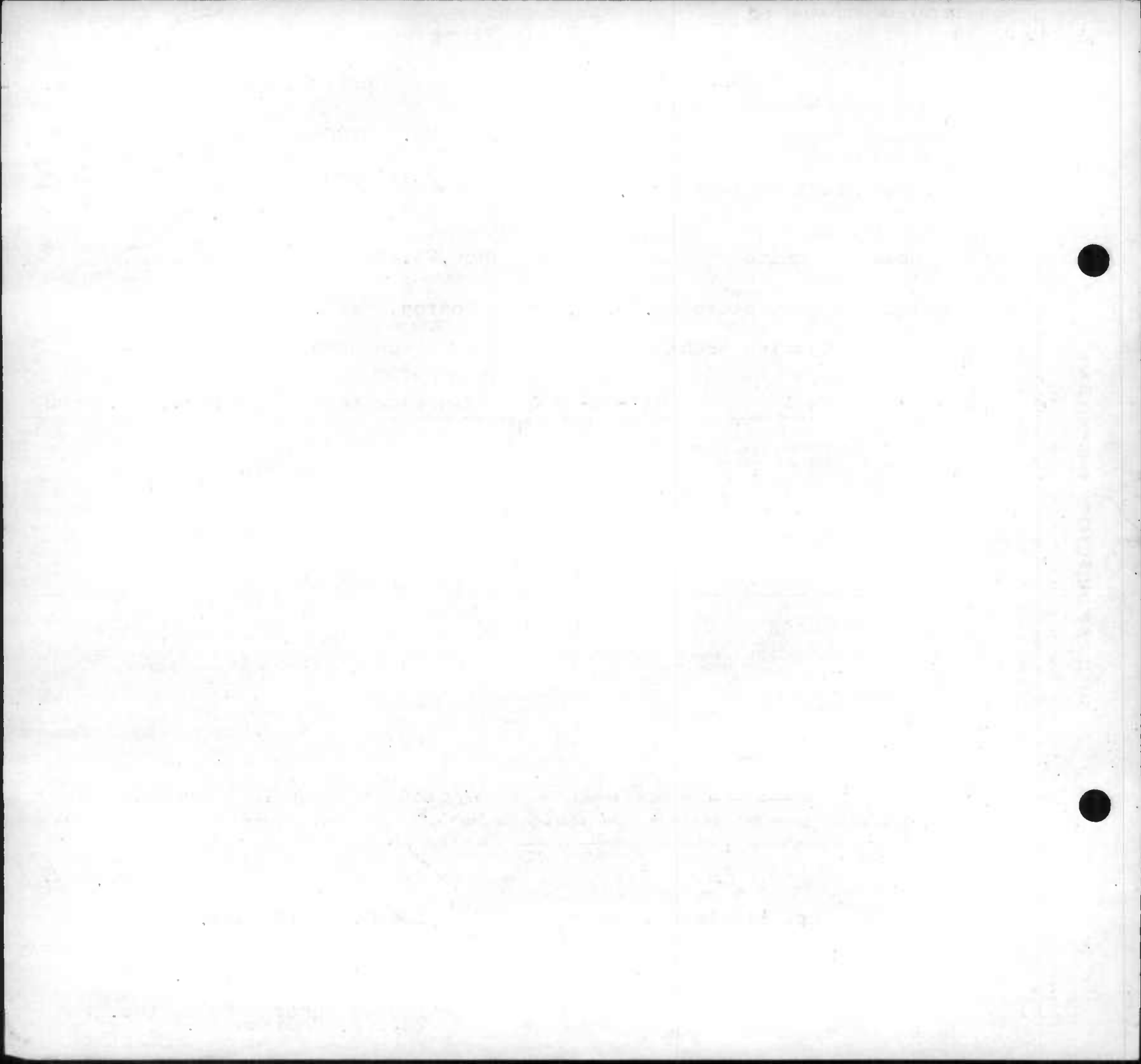
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3752 CERTIFICATE OF DEATH

REG. NO. 68- 3752

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CHARLES ARTHUR GRAHAM		April 3, 1968 12:15 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
2421 McElderry St.			Md., 21205		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2421 McElderry St.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday)
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 28, 1893	74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Police		Western Md. R. R.		Boston, Mass.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Charles Graham				unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes WW 1		217-01-1996		Florence Renshaw Graham, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Edema, Pneumonia, Septicoid		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Insuff.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Edema		
153.3 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-yr		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March-29-1968 to April-3-1968, that (I) (we) lost saw the deceased alive on April-2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. William G. Geyer				23B. DATE SIGNED April-4-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. William G. Geyer				156 N. Milton Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/6/68		Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 9 1968		Robert E. Farber		Schimunek Funeral Home, Inc. 2601 E. Madison St.	



68-3753

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3753

## BIRTH NO.

1. NAME OF DECEASED (or Sophie)  
(Type or Print) SOPHIA MANSON  
Mary2. DATE OF DEATH Known ☒ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)3. DATE PRONOUNCED DEAD Month Day Year Hour  
April 3, 1968 6:55 PM M.

2903 E. Monument Street

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX Female

7. RACE White

B. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 1/18/1885

10. AGE (In years lost birthday) 83

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER 2903 E. Monument Street

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Klima

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char-lady

14B. KIND OF BUSINESS OR INDUSTRY Balto. City

15. MOTHER'S MAIDEN NAME unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 214-16-3194

18. INFORMANT ADDRESS Melvin Manson, son, 422 N. Kenwood Ave. 24

MEDICAL CERTIFICATION	19. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  433.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
	21. AUTOPSY? (Yes or No) No		
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate, M.D.  
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED April 4, 1968

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 4/8/68

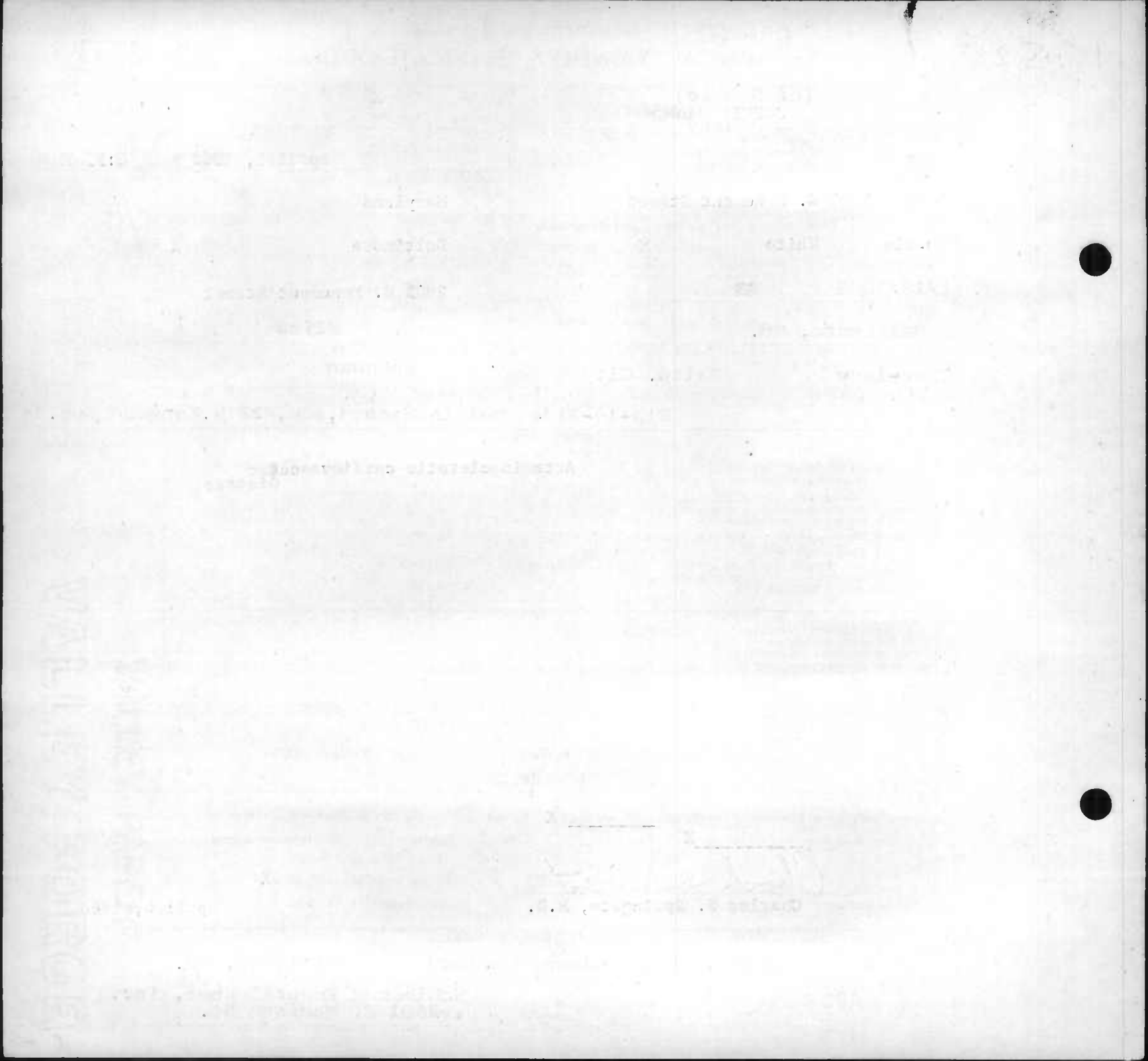
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. APR 9 1968

25B. NAME OF REGISTRAR Robert E. Fairbanks

25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.



6-654

68-3754

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-3754

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>G. MARGARET GREENWALD</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 3, 1968 9:50 P.M.</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Nov. 11, 1924</b>		10. AGE (In years lost birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>self-employed</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Seidel Bowling Alley</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-22-5753</b>	
15. MOTHER'S MAIDEN NAME <b>Catherine Klein</b>		18. INFORMANT ADDRESS <b>Catherine Greenwald, dght. above</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 4, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>	
25C. FUNERAL DIRECTOR <b>Schimmek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	

1

RECEIVED

NOV 11 1964

TO :

FROM :

SUBJECT :

RE :

DATE :

TIME :

BY :

CC :

FILE NO. :

REMARKS :

INITIALS :

SIGNATURE :

DATE :

11-11-64

RECEIVED

NOV 11 1964

TO :

FROM :

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RE :

DATE :

TIME :

BY :

CC :

FILE NO. :

REMARKS :

INITIALS :

SIGNATURE :

DATE :

11-11-64

NOV 11 1964

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3755

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LAURA LIGHTNER PARKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 3, 1968</b>		Hour <b>6:58 A</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 3, 1968</b>		Hour <b>6:58 A</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>223 N. Wolfe Street</b>	
9. DATE OF BIRTH <b>5/9/21</b>		10. AGE (In years last birthday) <b>46</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Joseph Parker</b>		14. MOTHER'S MAIDEN NAME <b>Sissy Parker</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. SOCIAL SECURITY NO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>ROSE LEE PARKER</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b> <b>Fatty Metamorphosis of Liver</b>					
20A. DATE OF OPERATION <b>4/2/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-3-68</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus mem. RR</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Joseph B. Locks</b>		25D. ADDRESS <b>1304 N. Central Ave</b>			

4/18/68 - Insurance policy from Home Beneficial Life Insurance Company.

Insured: LAURA PARKER - Policy #64298625 - issued, 7/20/1964 -

age next birthday: 44.

*Jeff Carter*

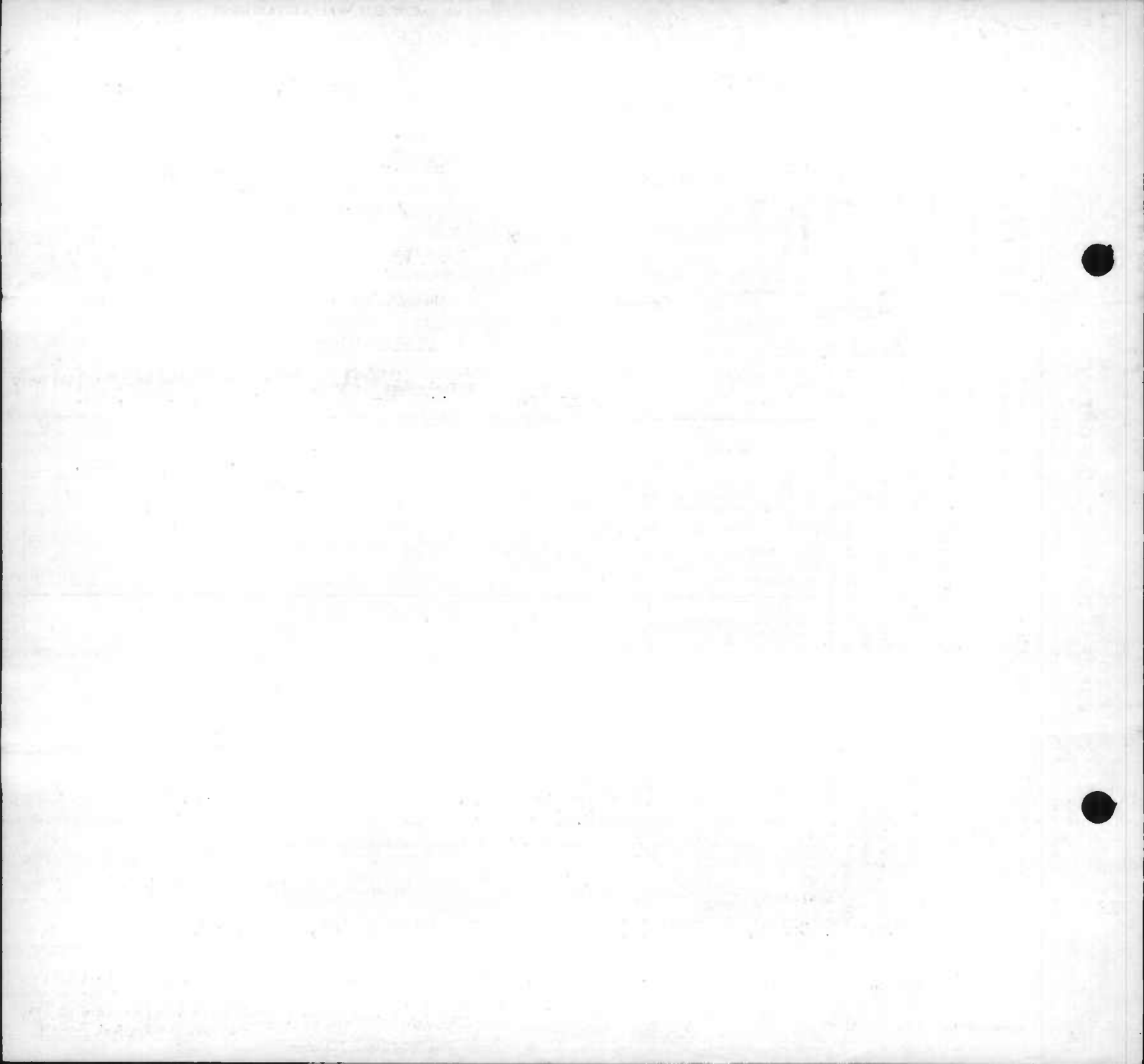
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3756 CERTIFICATE OF DEATH

REG. NO. 68- 3756

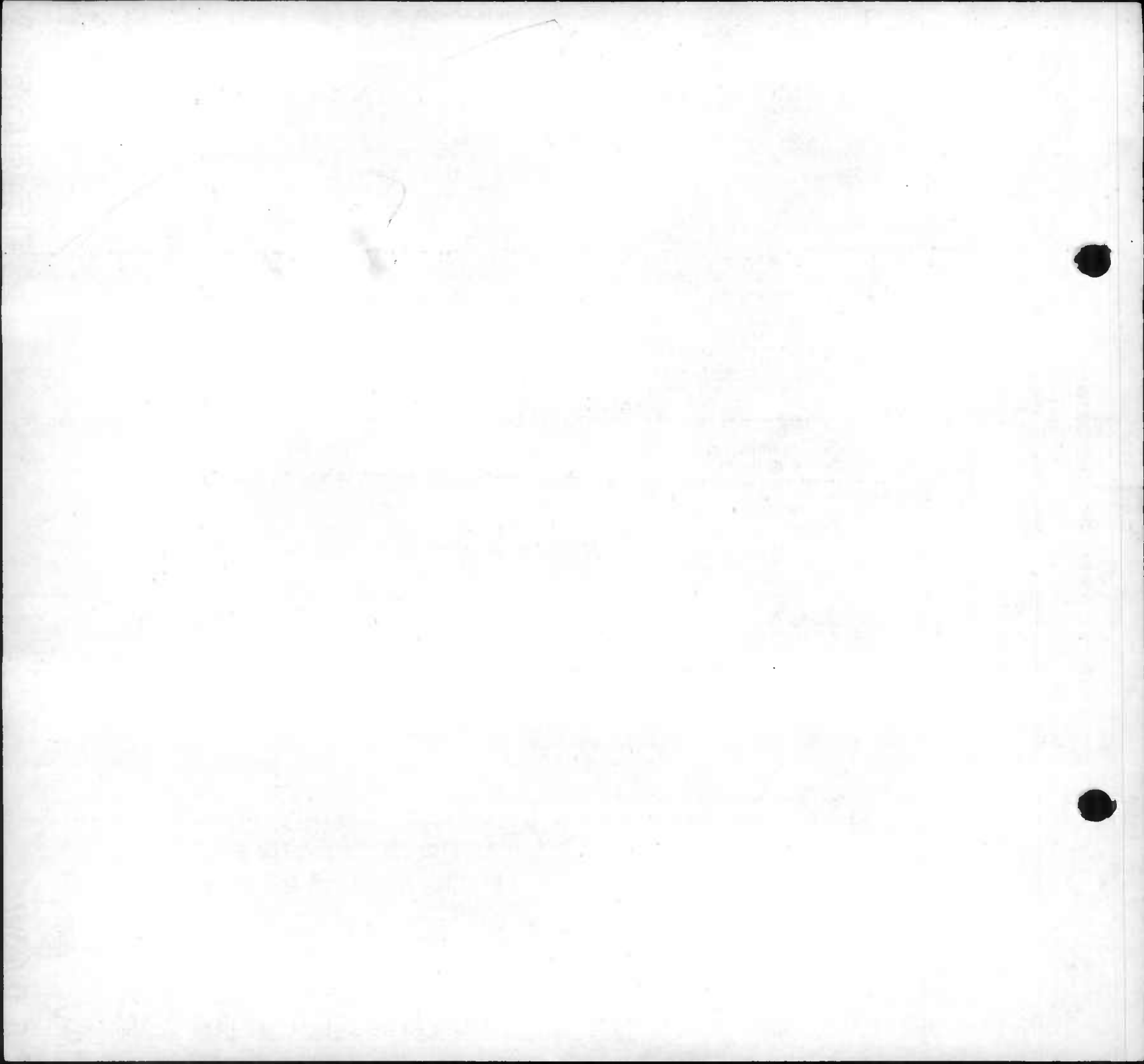
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>William John Fox</b>		2. DATE AND HOUR OF DEATH <b>April 3, 1968</b>   <b>11:35 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Harford</b> <b>62-32</b>		C. CITY OR TOWN <b>Bel Air</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>3100 Wyman Pk. Drive</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/15/53</b>		9. AGE (In years lost birthday) <b>15</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James T. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Miriam Dingman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-28-1906</b>		17. INFORMANT (Print) <b>James T. Fox</b> <b>9 Shamrock Rd, Bel Air, Maryland 21014</b> <b>Records- US PHS Hospital, Balto, Md.</b>	
18. <b>153.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Embryonal cell carcinoma of intestines</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>	
19. <b>153.9 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>no</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Mar. 25</b> 19 <b>68</b> to <b>Apr. 3</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Apr. 3</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (d/d not) view the body after death.					
23A. SIGNATURE <b>Henry S. Crist, M.D.</b>				23B. DATE SIGNED <b>4/4/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Henry S. Crist, SA Surg (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 6, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>BEL AIR MEMORIAL GARDENS</b>	
24D. LOCATION (City, town, or county) (State) <b>BEL AIR, Harford Co., Maryland 21014</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fawcett</b>		25C. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>W. Broadway &amp; Williams St</b> <b>BEL AIR, Maryland 21014</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="float: right;">68-3757</span>	
W-300		68-3757		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HENRY WHITE</b>		2. DATE AND HOUR OF DEATH <b>APRIL 6 1968 2:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>38 UNIVERSITY OF MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1501 MOSHER ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/1/07</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHNNY WHITE</b>		14. MOTHER'S MAIDEN NAME <b>ANNA LAND</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-09-0369</b>		17. INFORMANT <b>CHART</b>	
18. <b>401X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PROBABLE SEPSIS</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSION &amp; UREMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>444X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>March 26 19 68</b> to <b>April 6 19 68</b> , that (1) (we) last saw the deceased alive on <b>April 6 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William H. Barker, Jr. MD</b>		23B. DATE SIGNED <b>4/6/68</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. BARKER, JR. MD</b>		23D. ADDRESS <b>UNIV. MD. HOSPITAL BALTO. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-18-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Smt. Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, MD</b>	
25C. FUNERAL DIRECTOR <b>Alton General Home 1348 Calhoun St</b>		25D. ADDRESS			



1  
W-425 68-3758 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-3758

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALBERT WILSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1103 Stockton Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 7, 1968 4:00 A. M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-28-28</b>		10. AGE (In years lost birthday) <b>38</b>		E. STREET AND NUMBER <b>1103 Stockton Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Herman Cottman</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Grace Wilson</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 10/17/50*7/17/52</b>		17. SOCIAL SECURITY NO. <b>231203229</b>		18. INFORMANT ADDRESS <b>Esther Wilson same</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>746.61</b> <b>Aortic stenosis (congenital deformity) and arteriosclerotic coronary artery disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 7, 1968</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-11-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
24G. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		24H. ADDRESS <b>1348 Calhoun St.</b>		24I. DATE <b>April 7, 1968</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3759 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68- 3759

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROBERT H. CABEAN		04-5-68 3 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND	
				B. COUNTY	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1731 ASHLAND AVENUE	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-13	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelmaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester S. C.	
13. FATHER'S NAME WILLIE Cabean				14. MOTHER'S MAIDEN NAME ETHEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Eutelo Cabean 1731 Ashland Ave	
18. 412.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intracranial Hemorrhage 40 HRS (B) HAS CVD (C)	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II Hypertension					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/3 1968 to 4/5 1968, that (I) (we) last saw the deceased alive on 4/5 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry K. Genant				23B. DATE SIGNED 4/5/68	
23C. PHYSICIAN'S NAME (Type) HARRY K. GENANT				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 11/68		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
24D. LOCATION A. A. County Md		25A. DATE REC'D BY HEALTH DEPT. APR 9 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank J. Eliehan 1129 N. Carroll St		25D. ADDRESS	

on oak

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Minnie Simms

2. DATE AND HOUR OF DEATH

4-6-68

9:30

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1628 E. Biddle Street 21213

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-3-1894

9. AGE (In years  
last birthday)

74

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew Coleman

14. MOTHER'S MAIDEN NAME

Martha

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records; BCH-4940 Eastern Avenue 21224

18. 201X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Meningitis, gram negative

(B) DUE TO, OR AS A CONSEQUENCE OF:

Hodgkins Disease

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

201X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-5 1968 to 4-6 1968,  
that (I) (we) last saw the deceased alive on 4-6-68 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mark Lowmiller

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-6-68

23C. PHYSICIAN'S  
NAME (Type)

Mark Lowmiller

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Feltner

25C. FUNERAL DIRECTOR

Frank E. Elickson 1129 N. Charles St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

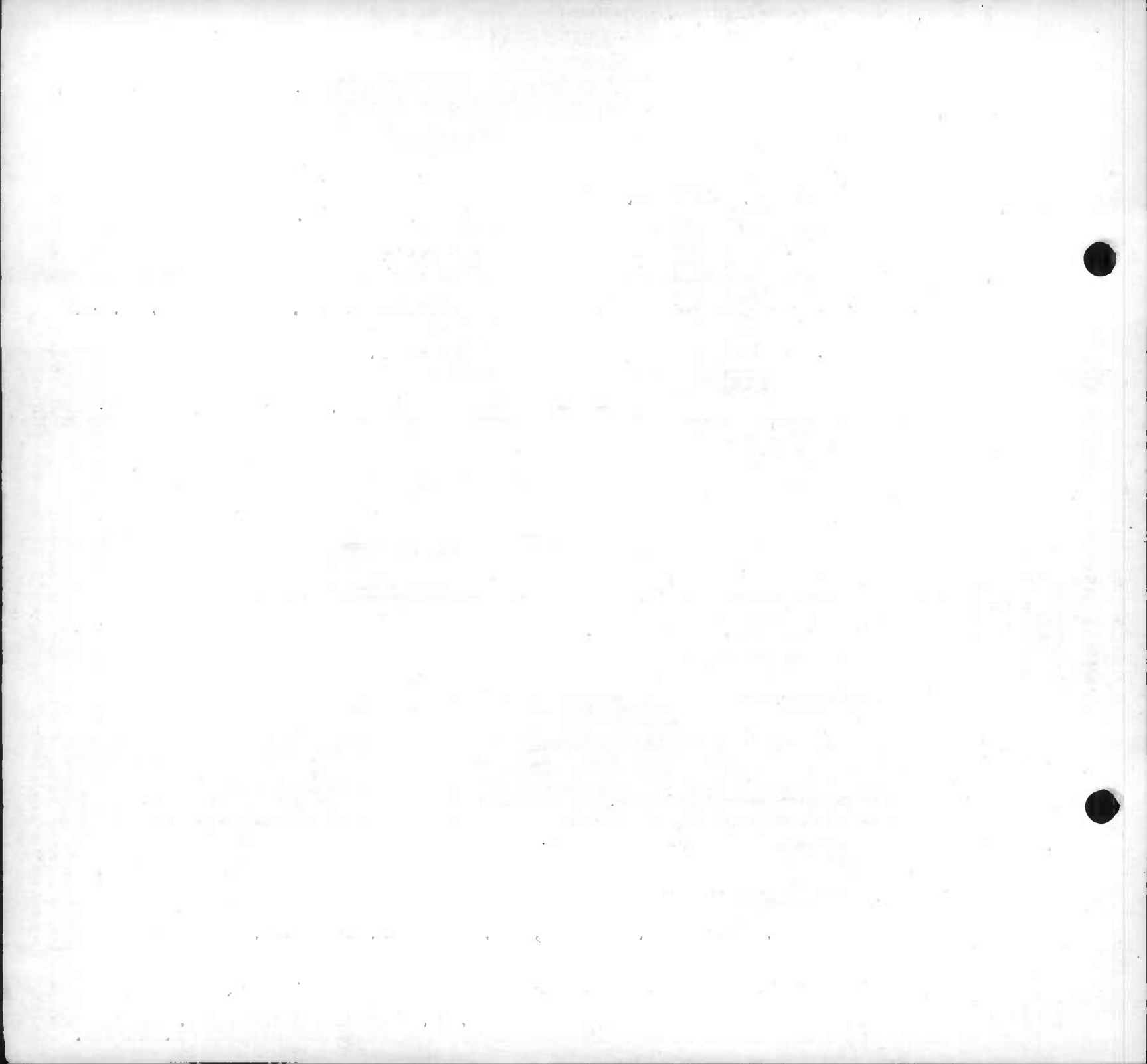
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3761

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3761

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Florence Mills McGuire</b>		2. DATE AND HOUR OF DEATH <b>April 7, 1968</b> <b>4:30 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore 21218</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>412 E. 31st St.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1883</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George H. Mills</b>		14. MOTHER'S MAIDEN NAME <b>Susan S. Morris</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-1405</b>		17. INFORMANT <b>Miss Alice P. McGuire</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple cerebral vascular thromboses</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Diabetes mellitus</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION <b>4-22-61</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>April 3</b> 19 <b>59</b> to <b>April 7</b> 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 7</b> 19 <b>68</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.		23A. SIGNATURE <b>Alfred G. Ossman Jr.</b>	
23B. DATE SIGNED <b>April 9, 1968</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Alfred G. Ossman, Jr. 1101 St. Paul St.</b>		23D. ADDRESS <b>Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 8 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd Balto. 12, Md.</b>		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

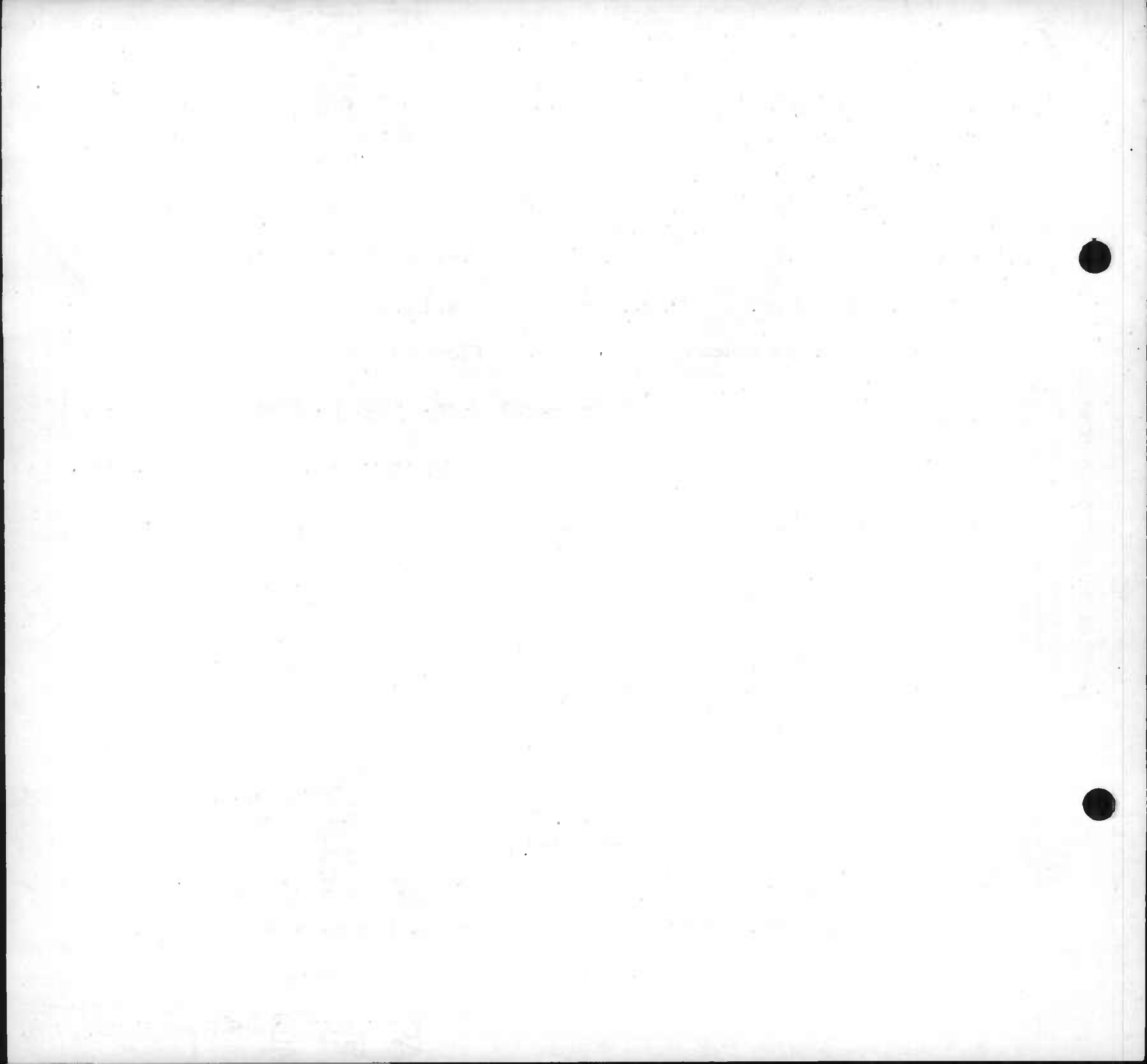
68-3762

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-3762

BIRTH NO.		1. NAME OF DECEASED (Type or Print) George Herbert Mackelcan		2. DATE AND HOUR OF DEATH 4-7-68 8:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 318 Paddington Road		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 318 Paddington Road	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1881	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sales Mgr.		10B. KIND OF BUSINESS OR INDUSTRY U. S. Steel		11. BIRTHPLACE (State or foreign country) Hamilton, Ontario	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry A. Mackelcan		14. MOTHER'S MAIDEN NAME Florence Walker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-2323		17. INFORMANT Mrs. Alice N. Mackelcan	
18. 492 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emphysema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 5271 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from May 19 58 to April 7 19 68, that (I) (we) last saw the deceased alive on Sept. 28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Dr. John Scott	
23B. DATE SIGNED 4-8-68		23C. PHYSICIAN'S NAME (Type) Dr. John Scott		23D. ADDRESS 600 W. Belvedere Ave. Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-9-68		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore,		24E. STATE Md.		25A. DATE REC'D BY HEALTH DEPT. APR 8 1968	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		25D. ADDRESS 21212 4905 York Road Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

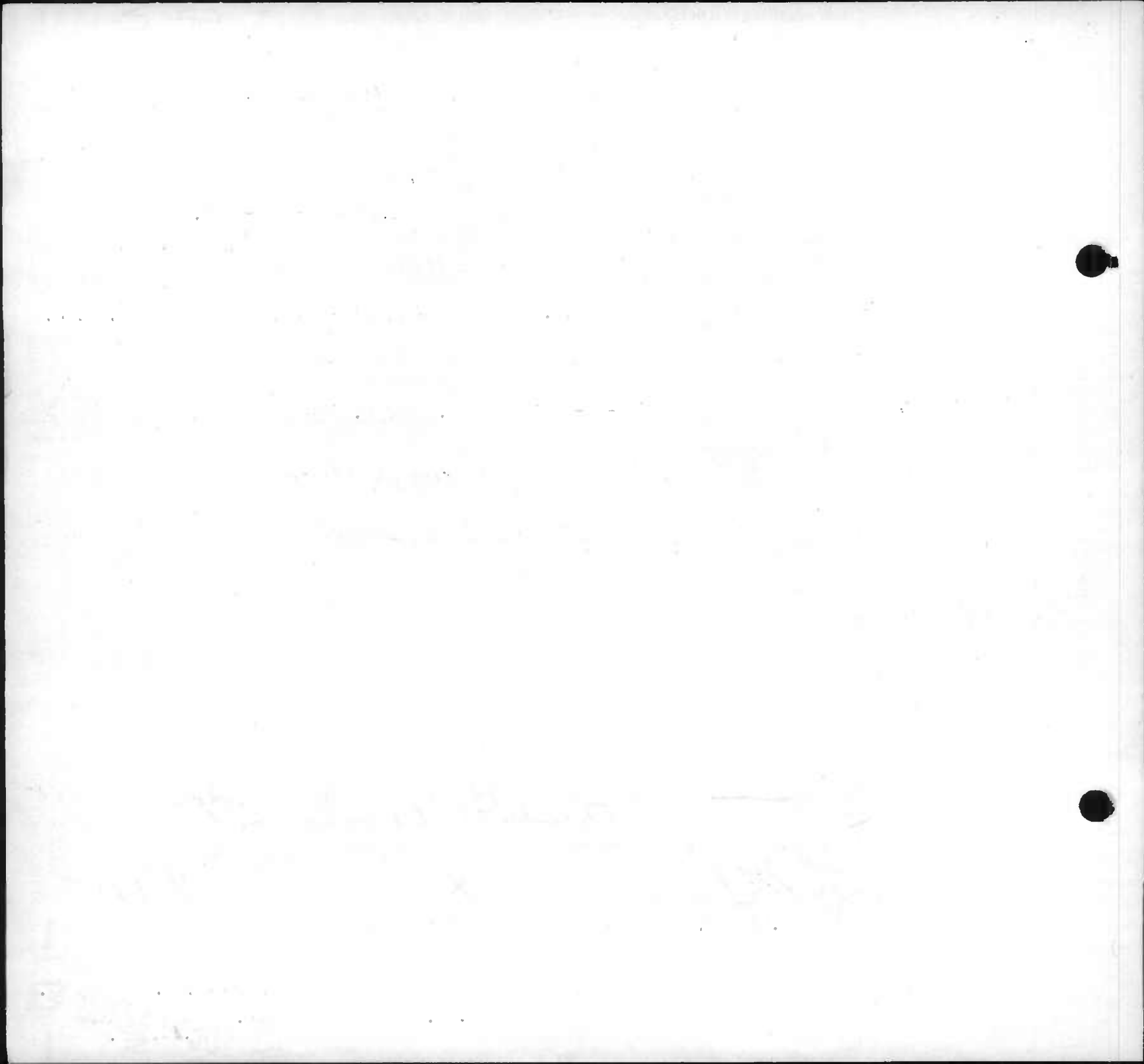
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3763

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3763

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Joseph Ford</b>		2. DATE AND HOUR OF DEATH <b>April 5, 1968</b> <b>5:00 A.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>44 Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/29/1888</b>		9. AGE (In years last birthday) <b>79</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Lead Burner Standard Oil Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Clayton, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Charles Reese Ford</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane Weller</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-4420A</b>	
17. INFORMANT <b>Mrs. Julia B. Ford</b>		ADDRESS (Same)		18. CAUSE OF DEATH	
MEDICAL CERTIFICATION DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>4/20/68</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Occlusion</b> (B) <b>Arteriosclerotic Cardio-Vascular Disease</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>5 years</b>	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1963</b> to <b>April 1</b> 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>December 21</b> 19 <b>67</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.		23A. SIGNATURE <b>Dr. Loy M. Zimmerman</b>		23B. DATE SIGNED <b>4/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Loy M. Zimmerman</b>		23D. ADDRESS <b>3202 Harford Road</b>		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) <b>Parkville, Balto. Co.</b>		(State) <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto. Md.</b>	



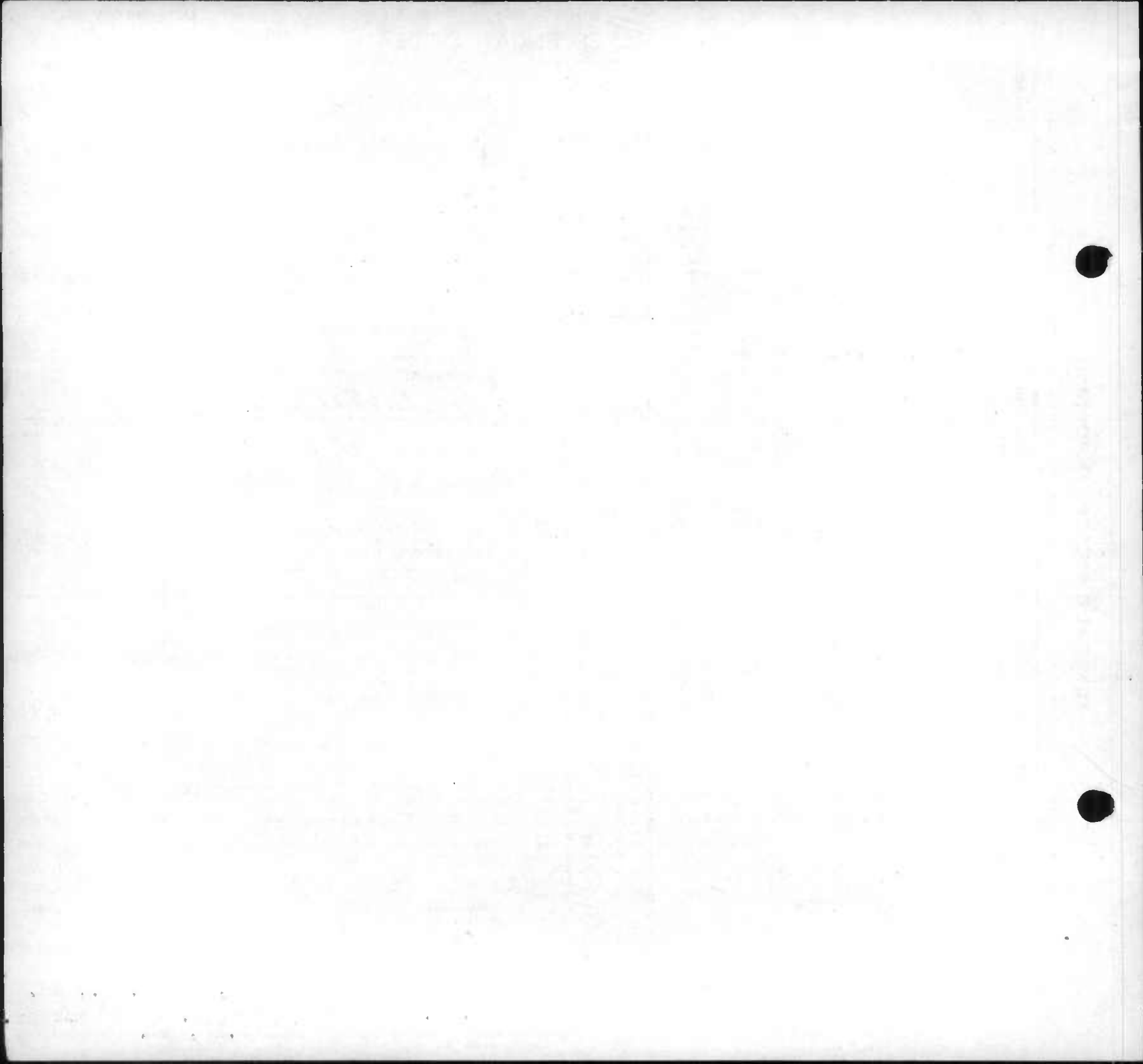
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3764 CERTIFICATE OF DEATH

REG. NO. 68- 3764

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Vernette M. Davis</i>		2. DATE AND HOUR OF DEATH <i>4-6-68</i> <i>1:26</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Hospital Baltimore</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-19-1903</i>		9. AGE (In years last birthday) <i>65</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Charles Robert</i>	
14. MOTHER'S MAIDEN NAME <i>Oline</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-32-2027</i>	
17. INFORMANT <i>Charles E. Davis (James)</i>		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Embolus</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>28 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>atrial fibrillation</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<i>12-13 yrs?</i>	
(C) <i>Rheumatic Heart Disease</i>					
19. DATE OF OPERATION <i>4-5-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>4-5-68</i> to <i>4-6-68</i> and that (II) (we) last saw the deceased alive on <i>4-6-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Harry L. Luman M.D.</i>		23B. DATE SIGNED <i>4-6-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Harry L. Luman</i>	
23D. ADDRESS <i>Lincoln Hospital Balt</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/10/68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, or county) (State) <i>Parkville, Balto. Co., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Rd. Balto. 12, Md.</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3765

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3765

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Schoestrand Donald</i>		2. DATE AND HOUR OF DEATH <i>4-5-68 10<sup>45</sup> pm M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i> Md </i> B. COUNTY <i> City </i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>49 N. Charles Hospital</i>				C. CITY OR TOWN <i>BALTIMORE</i> INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>2803 Overland av</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-17-11</i>	9. AGE (In years last birthday) <i>56</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INSPECTOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bendix Radio</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>	
13. FATHER'S NAME <i>Joseph Schoestrand</i>				14. MOTHER'S MAIDEN NAME <i>Stacy Frazier, Isabella O.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>206-01-1701</i>		17. INFORMANT <i>(Chart Hospital) Mrs. Sylvia J. Schoestrand</i>	
18. <i>427.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>434.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart Failure</i>  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-24</i> 19 <i>68</i> to <i>4-5</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-5</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>10<sup>45</sup> pm</i>					
23A. SIGNATURE <i>Luis E. Rengel</i>				23B. DATE SIGNED <i>4/5/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARION Friedman</i>				23D. ADDRESS <i>N. Charles Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/9/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Manchester Lut. Church</i>	
24D. LOCATION (City, town, or county) (State) <i>Manchester Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>APR 9 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore, Md. 21212</i>			

12-10-1912 to 12-10-1912

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3766

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 3766

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LUCILLE BRUBAKER KIEFER</b>		2. DATE AND HOUR OF DEATH <b>1:00 AM 4-3-68</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>ANNE ARUNDEL</b> <b>52-00</b>			
				C. CITY OR TOWN <b>ANNAPOLIS</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>Homewood Rd, Ferry Farm</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-88</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>GEORGE F. BRUBAKER</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH REAM.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>559-14-7508</b>		17. INFORMANT <b>Hospital Records.</b>	
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral thrombosis of brain stem</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASPIRATION PNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral thrombosis of brain stem</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>5 mo.</b>	
MEDICAL CERTIFICATION <b>332 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nativify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>12-27 1967</b> to <b>4-3 1968</b> , that (I) last saw the deceased alive on <b>4-2 1968</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.							
23A. SIGNATURE <b>John M. Coyne</b>						23B. DATE SIGNED <b>4-3-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. M. COYNE, M.D.</b>				23D. ADDRESS <b>MONTEBELLO STATE HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>4-6-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Ft. Lincoln</b>		24D. LOCATION (City, town, or county) (State) <b>Bladensburg MD.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>John M. Coyne</b>		25C. FUNERAL DIRECTOR <b>John M. Coyne &amp; Sons Annapolis, Md.</b>		ADDRESS	

11-4-88 JF

0410

221-14-1208 West. 1st Floor

Association President

General Director of the

11-4-88

11-4-88

11-4-88

Montgomery State West

Z. M. COYNE, M.D.

*[Signature]*

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CASIMIR JAWORSKI</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>4 6 68</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home and Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 6:55 A</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9-9-19</b>		10. AGE (In years lost birthday) <b>48</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HEAD SKI INC.</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		17. SOCIAL SECURITY NO. <b>217-09-6966</b>	
18. INFORMANT <b>ANNA JAWORSKI</b>		ADDRESS <b>1915 PRATT STREET</b>	
19. <b>398X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-9-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-6-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-9-68</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>QUINDARY MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>R. E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>JOHN M. WEBER &amp; SONS INC.</b>		ADDRESS <b>5 CHESTER ST.</b>	

4/22/68 - Marriage record Groom: CASIMIR WALTER  
JAWORSKI. Bride: ANNA MARY STROZYKOWSKI  
D.M. July 2, 1949. Groom divorced July 1948.  
Bride - Single. Lic. #16791. Elletts City, Ind.  
L.B. Carter

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3768	
BIRTH NO. 5-316 68-3768		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) STOPFORD, ESTHER		2. DATE AND HOUR OF DEATH 4/8/68 5:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSP. 4940 Eastern Ave. Baltimore, Maryland # 21224		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 26-41 E. STREET AND NUMBER 1248 Haverhill Rd. # 21229 007	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-15-27
9. AGE (In years last birthday) 40		10. IF Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Daniels		14. MOTHER'S MAIDEN NAME Rose Beckman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 219-20-8622 H	
17. INFORMANT		ADDRESS # 21224	
18. 340X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 345X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Decubiti, paraplegia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis (B) DUE TO, OR AS A CONSEQUENCE OF: UTI (C) Multiple Sclerosis	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/26/68 to 4/8/68, that (I) (we) last saw the deceased alive on 4/8/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Z Grossman, M.D.		23B. DATE SIGNED 4/8/68	
23C. PHYSICIAN'S NAME (Type) ZACHARY GROSSMAN M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-11-68	24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE	24D. LOCATION (City, town, or county) (State) Howard County Md.
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968 Robert C. Jankins		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
GEO. L. SCHWAB Funeral Home		Francis St. Miller 2101 Frederick Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">68- 3769</span>
<p style="font-size: 1.5em; margin: 0;">M-430</p> <p style="font-size: 1.5em; margin: 0;">68- 3769</p>		<p><b>CERTIFICATE OF DEATH</b></p>		
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">LOUISE E. MILES</span></p>		<p>2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">4-7-68</span>   <span style="font-size: 1.1em;">5:30</span> P.M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <span style="font-size: 1.1em;">BON SECOURS Hospital</span></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.1em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.1em;">BALTIMORE</span> C. CITY OR TOWN <span style="font-size: 1.1em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">4 SOUTH MONROE STREET</span></p>		
<p>5. SEX <span style="font-size: 1.1em;">FEMALE</span></p>	<p>6. RACE <span style="font-size: 1.1em;">CAUC.</span></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <span style="font-size: 1.1em;">1-17-07</span></p>	<p>9. AGE (In years lost birthday) <span style="font-size: 1.1em;">61</span></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">WAITRESS</span></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">TAVERN</span></p>		<p>11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">VIRGINIA</span></p>
<p>12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span></p>		<p>13. FATHER'S NAME <span style="font-size: 1.1em;">JETT BRYANT</span></p>		
<p>14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Julia HANEY</span></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">NO</span> <span style="font-size: 1.1em;">NONE</span></p>		
<p>16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">213-32-3678</span></p>		<p>17. INFORMANT <span style="font-size: 1.1em;">LONDON MILES - SON</span> ADDRESS <span style="font-size: 1.1em;">SAME</span></p>		
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">Hemopericardium</span></p> <p>(B) RUPTURED ACUTE MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.1em;">1 day</span></p> <p>(C) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>				
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.1em;">420.1 II</span></p>				
<p>19A. DATE OF OPERATION <span style="font-size: 1.1em;">2</span></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span></p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">4-6-</span> <span style="font-size: 1.1em;">1968</span> to <span style="font-size: 1.1em;">4-7-</span> <span style="font-size: 1.1em;">1968</span>, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">4-7-</span> <span style="font-size: 1.1em;">1968</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <span style="font-size: 1.1em;">Hashemi</span> M.D. DEGREE</p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>		<p>23B. DATE SIGNED <span style="font-size: 1.1em;">4-7-68</span></p>
<p>23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">HASHEMI</span> M.D. DEGREE</p>		<p>23D. ADDRESS <span style="font-size: 1.1em;">BON SECOURS Hospital</span></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">BURIAL</span></p>	<p>24B. DATE <span style="font-size: 1.1em;">4-10-68</span></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.1em;">LONDON PARK</span></p>		<p>24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">BALTIMORE, MARYLAND</span></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">APR 9 1968</span></p>		<p>25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Faldut</span></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">GEO. L. SCHWAB Funeral Home, Francis H. Miller 2101 Redwood Ave</span></p>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3770</u>	
B-520		68-3770		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Vincent S. Bianco</u>			2. DATE AND HOUR OF DEATH <u>4-5-68</u> <u>7:20 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home and Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>53-00</u> C. CITY OR TOWN <u>Baltimore Co.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1116 Beech Drive</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-04</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Frederick Faber</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Salvatore Bianco</u>			
14. MOTHER'S MAIDEN NAME <u>Marian Tisazza</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>#</u>			
16. SOCIAL SECURITY NO. <u>218-10-5399</u>		17. INFORMANT <u>Mrs Doris C. Bianco</u> ADDRESS <u>1619 N. Chapel ST.</u>			
18. <u>577.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>577.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Anti peroneal fits (?) 2 days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <u>4-3-68</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Duodenal ulcer &amp; pyloric stenosis</u>		
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>3-26</u> 19 <u>68</u> to <u>4-5</u> 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>4-5</u> 19 <u>68</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>R. Mason</u>			23B. DATE SIGNED <u>4-5-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Ricardo M. T. Mason</u>			23D. ADDRESS <u>Church Home &amp; Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR <u>HENRY SANDER &amp; SONS INC.</u> <u>BALTIMORE MARYLAND 21213</u>			

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4-3-68 Continued release of prisoners for

Chase at home + hospital

7-7-68

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
CERTIFICATE OF DEATH																			
REG. NO. <u>68-3771</u>																			
BIRTH NO. <u>68-3771</u>					1. NAME OF DECEASED (Type or Print) <u>JACK G. CODY</u>					2. DATE AND HOUR OF DEATH <u>4-5-68</u> <u>4:45</u> P. M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSP.</u>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>26-34</u>									
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH <u>1-14-02</u>					9. AGE (In years last birthday) <u>66</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>										10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>					11. BIRTHPLACE (State or foreign country) <u>MD. BALTO</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>										13. FATHER'S NAME <u>Rolland Cody</u>									
14. MOTHER'S MAIDEN NAME <u>Grace Francis Biddle</u>										15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>									
16. SOCIAL SECURITY NO. <u>219224393</u>										17. INFORMANT <u>Mrs Camillus Cody</u>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>441.2 I</u> <u>Ruptured Abdominal Aortic Aneurysm</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/4/68</u>									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>451X II</u> <u>Acute Appendicitis, pyloric Obstruction</u>										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ruptured Abdominal Aortic Aneurysm</u>									
(B) <u>Arteriosclerotic Cardiovascular Disease</u>										DUE TO, OR AS A CONSEQUENCE OF:									
(C) <u>C.V.K. Wu</u>										DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>451X II</u>										20A. AUTOPSY? (Yes or No) <u>YES</u>									
19A. DATE OF OPERATION <u>4/8/68</u>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured Abdominal Aortic Aneurysm</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)									
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>4/14/68</u> to <u>4/15/68</u> , that (I) (we) last saw the deceased alive on <u>4/15/68</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										23A. SIGNATURE <u>Charles H. Classen</u>									
23B. DATE SIGNED <u>4/15/68</u>										23C. PHYSICIAN'S NAME (Type) <u>DR CHARLES H. CLASSEN</u>									
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>										24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>									
24B. DATE <u>4/8/68</u>										24C. NAME of CEMETERY or CREMATORY <u>MORELAND MEM. PARK</u>									
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>										25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>									
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>										25C. FUNERAL DIRECTOR <u>DIPPEL BRO'S INC 7100 Belair Rd</u>									

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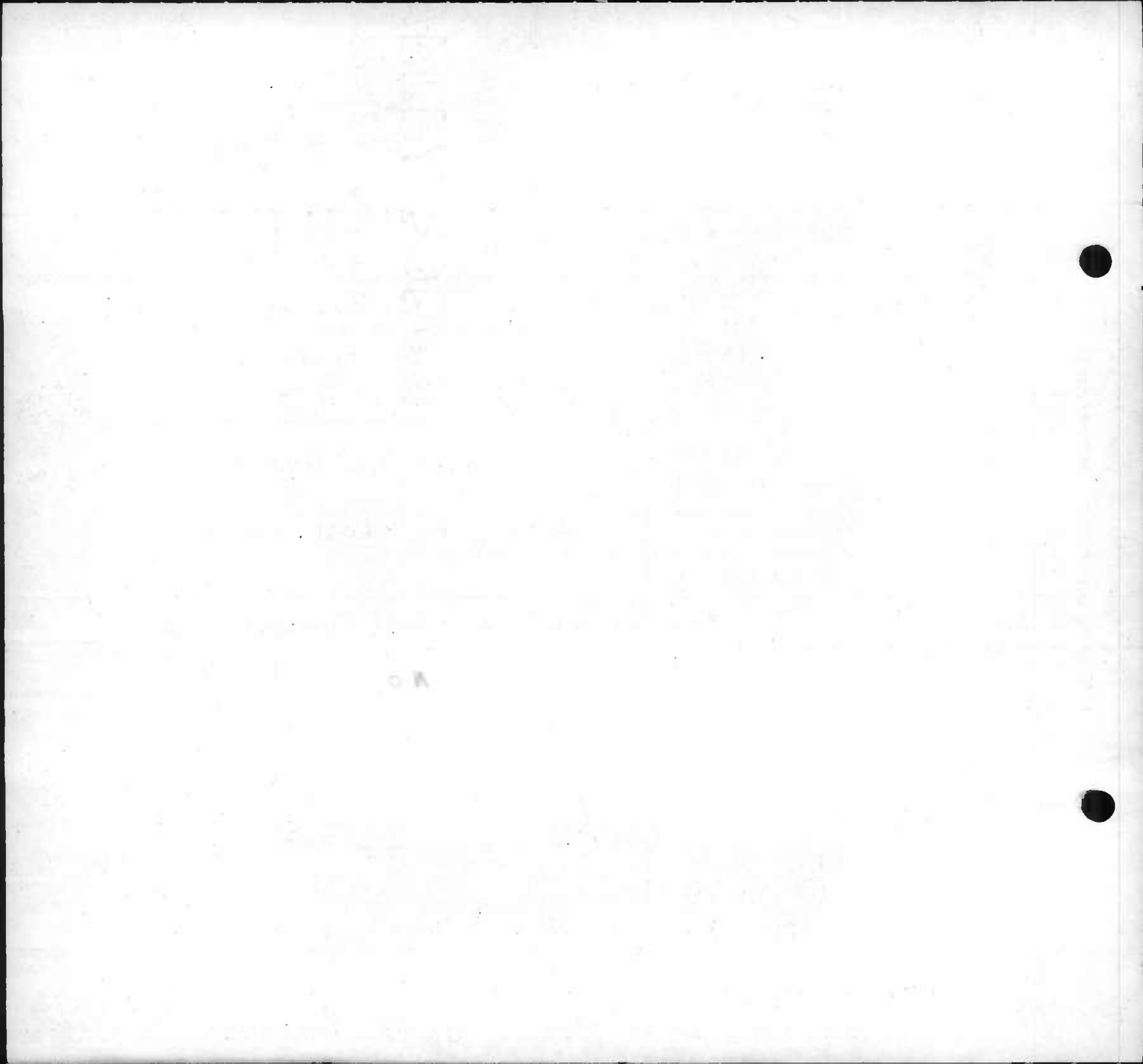
1-14-02

1-14-02

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

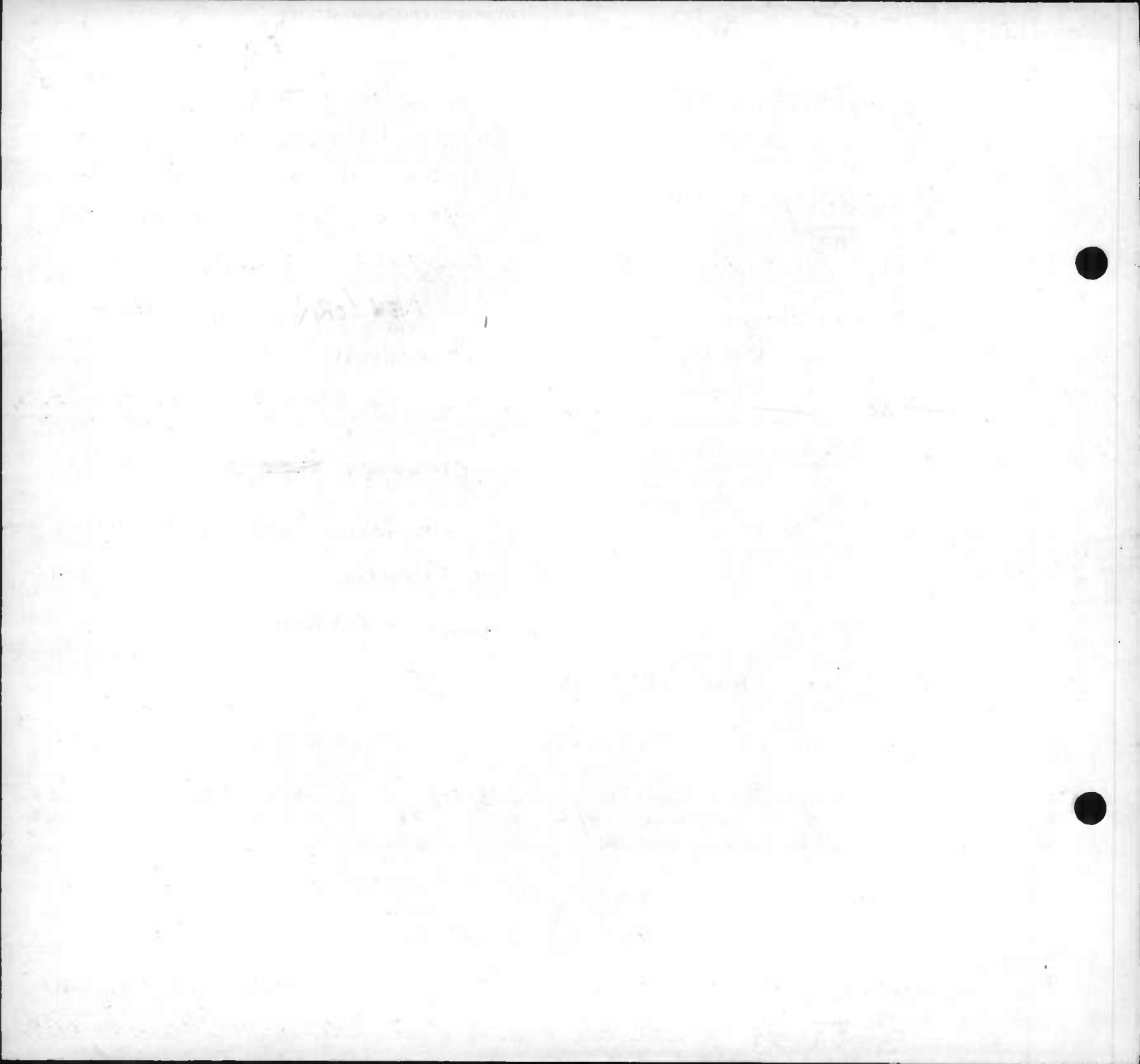
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-3772	
BIRTH NO. 68-3772										CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MB. Minnie L. Warthen					2. DATE AND HOUR OF DEATH X 17 188 12 20 P M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2129344C 53-00						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Montebello Hosp. Balto.					C. CITY OR TOWN Towson				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 1116 Compens Ave											
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/1875		9. AGE (In years last birthday) 92		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. MD.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm E. Blake					14. MOTHER'S MAIDEN NAME Victoria Thrift						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 213-52-7271		17. INFORMANT Wm. H. F. Warthen				
					ADDRESS 1116 Compens Ave, Balto						
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Bilat anterior Cerebral Artery Thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 day less	
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 3 19 68 to Apr 7 19 68, that (I) (we) last saw the deceased alive on Aug 7 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Hea Rean LEW					DEGREE			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Hea Rean LEW					23D. ADDRESS Montebello Hosp						
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 4/10/68		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK CEM			24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968					25B. NAME OF REGISTRAR Robert E. Jackson			25C. FUNERAL DIRECTOR DIPPEL BRO'S INC.		ADDRESS 7110 BELAIR RD.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 3773
68- 3773 CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">X</span>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Bailey John R</b>		
2. DATE AND HOUR OF DEATH <b>April 2, 1968</b>		<b>4 13 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>Carroll C</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Md. Hospital</b>		C. CITY OR TOWN <b>Westminster</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>Rt #6 Old Washington Rd</b>				
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/05</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Hanger</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>William C. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Goodrich (Idn).</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unk No</b>		16. SOCIAL SECURITY NO. <b>212-14-1330</b>		17. INFORMANT <b>John W. BAILEY Westminster Rt#6 Md.</b>
18. <b>188X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>181.0 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>emphysema + bronchitis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>SURGERY FOR BOWEL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>CA of Bladder</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 days</b> <b>1-2 yrs.</b>
19A. DATE OF OPERATION <b>4/1/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>3/30/1968</b> to <b>4/2/1968</b> , that (I) (we) last saw the deceased alive on <b>4/2/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>GARY L. Nobel MD</b>		23B. DATE SIGNED <b>4/2/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>GARY L. Nobel</b>		23D. ADDRESS <b>Univ. Hosp -</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Zion Methodist Cemetery Westminster Rd #6 Md.</b>
24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltman</b>		25C. FUNERAL DIRECTOR <b>J. E. Myers Jr., Westminster Md.</b>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3774

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HELEN H. HEINBUCH (HEINBUCH)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 1, 1968</b> Hour <b>10:00 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>1218 S. Clinton Street # 21224.</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>April 2, 1968</b> Hour <b>6:38 A.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b>	
6. SEX <b>female</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 19, 1929</b>	10. AGE (In years last birthday) <b>39</b>	11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Morgan</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		15. MOTHER'S MAIDEN NAME <b>Helen Mauritz</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>214-26-3064</b>	
18. INFORMANT <b>Ernest W. Heinbuch</b>		ADDRESS <b>1218 S. Clinton St. #24</b>	
19. CAUSE OF DEATH <b>412.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> DATE SIGNED <b>4/2/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-68.</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>Charles S. Feiler</b>		25D. ADDRESS <b>901 1st Bankling St. Balto., 21224, Md.</b>	

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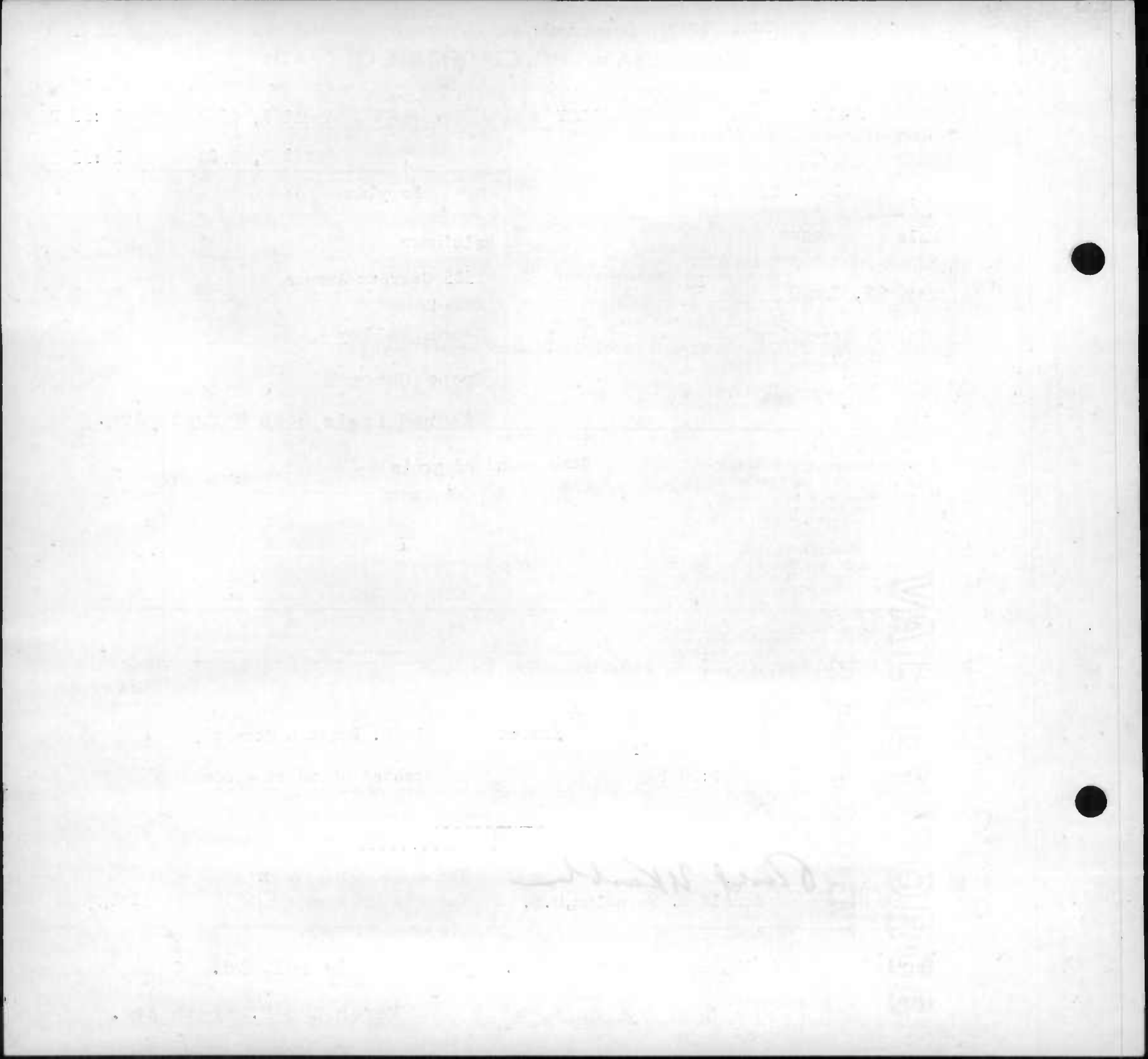
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3775

REG. NO.

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES A. MALLOY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 7, 1968</b> Hour <b>10:55 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>910 E. Preston Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 7, 1968</b> <b>10:55 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 23, 1929</b>		10. AGE (In years last birthday) <b>38</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Irene Camoran</b>		18. INFORMANT <b>Mildred Lewis</b>	
13. FATHER'S NAME <b>Lemon Malloy</b>		ADDRESS <b>2525 Garrett Ave.</b>	
19. <b>E966 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Stab wound of groin</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>4-8-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22D. TIME OF INJURY (APPROX.) <b>4 7 68 9:30 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>910 E. Preston Street</b>		22F. HOW DID INJURY OCCUR? <b>Stabbed wound of groin</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-8-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/12/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Laural, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Ronald E. Farley, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3776</u>
68-3776				CERTIFICATE OF DEATH
BIRTH NO. <u>CHRISTINA SLITZER</u>		2. DATE AND HOUR OF DEATH <u>4-6-68 12:30 A.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>CHRISTINA SLITZER</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1-03</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>35 CAURCH HOME AND HOSP</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 CAURCH HOME AND HOSP</u>		E. STREET AND NUMBER <u>527 LAKEWOOD AVE</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/92</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>Paul Boehm</u>		
14. MOTHER'S MAIDEN NAME <u>Gertrude</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry A. Slitzer</u> ADDRESS <u>527 S. Lakewood Ave.</u>		
18. <u>1997</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hepatic Coma</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Metastatic Disease, Liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
156.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Upper GI Bleeding</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-5-68</u> 19 <u>68</u> to <u>4-6-68</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4-6-68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Rodelio M. Lim</u>		23B. DATE SIGNED <u>4-6-68</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Rodelio M. Lim</u>		23D. ADDRESS <u>CHH</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-9-1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State) _____		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldy</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</u>

UNRECORDED

F W

CHANCE HERE AND HERE

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10/10/12

FUNERAL DIRECTOR: IMPORTANT

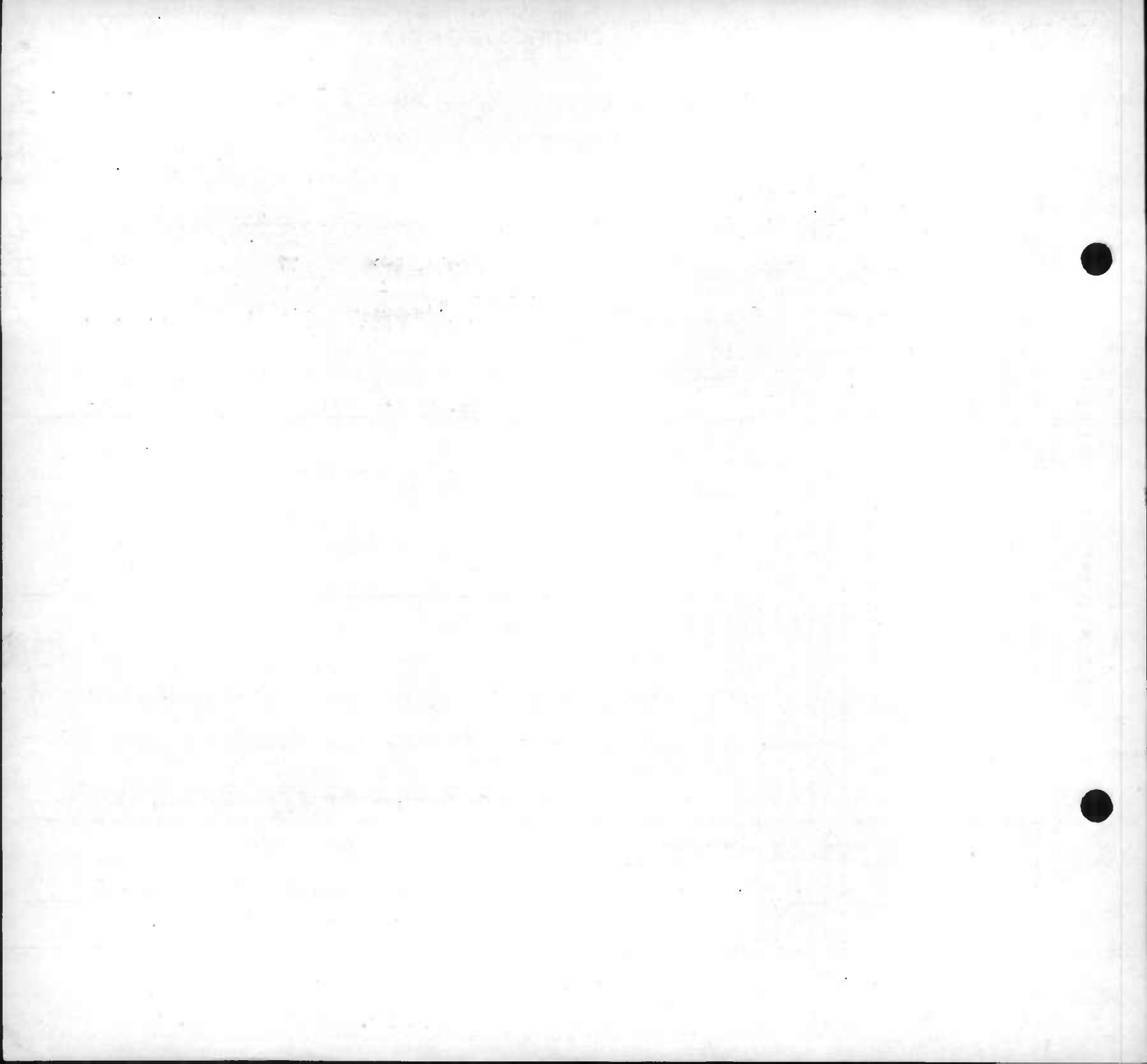
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3777

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3777

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Pinkney Byrd		4-1-68 12:55 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
39 Provident Hospital 1514 Division Street Baltimore, Maryland				Maryland	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore, YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				1400 John Street	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	Negro			July 4, 1890	77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		King & Queen County, Va	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Alexander West				Betty Blueford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Lottie Hall 4002 Oakford Ave	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro Vascular Accident					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February 24, 1968 19 to April 1, 1968 19, that (I) (we) last saw the deceased alive on April 1, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				4-1-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				Provident Hospital, Inc. 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/6/68		Carver Memorial Park	
				Laurel Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 9 1968		Robert E. J. J. J.		Herbert E. Nutter 3035 W. North Ave	



5-346

68- 3778 BALTIMORE CITY HEALTH DEPARTMENT

68- 3778

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

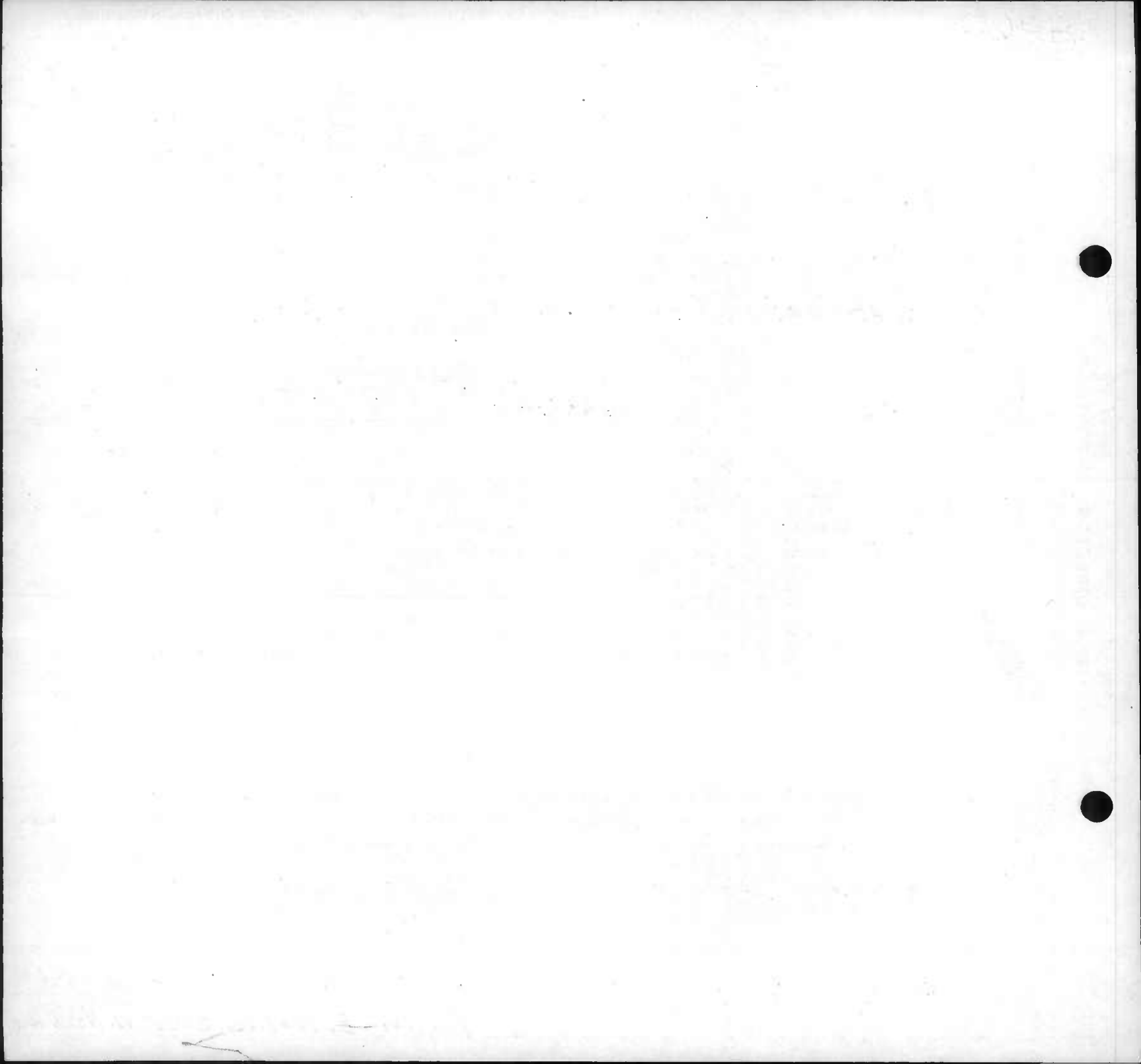
1. NAME OF DECEASED (Type or <b>ANNIE</b> <b>SUDLER</b> )		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 1, 1968</b> Hour <b>5:00 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1710 Warwick Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 1, 1968</b> <b>5:00 A.M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 18, 1913</b>		10. AGE (In years last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Polk</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
15. MOTHER'S MAIDEN NAME <b>Katie ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>215-12-8034</b>		18. INFORMANT <b>Mr. Matthew Pryor</b> ADDRESS <b>1710 Warwick Ave</b>	
19. <b>412.91</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Obesity</b>		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>4/22/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>4/1/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>	
25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		ADDRESS <b>3035 W. North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-3779
BIRTH NO.		68-3779			
1. NAME OF DECEASED (Type or Print)		EMMITT ARGUNES		2. DATE AND HOUR OF DEATH 3/30/68 10:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD.		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQ. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 211 N. CAREY ST #28			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) VA. (Sakoda)	
13. FATHER'S NAME RICHARD ARGUNES		14. MOTHER'S MAIDEN NAME EMMER KENNER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-3402		17. INFORMANT DAUGHTER - OTELIA	
				ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 437.9 I Cerebro Vasc. Accident		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC condition		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 mos and recent	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30 1968 to 3/30 1968, that (I) (we) last saw the deceased alive on 3/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert E. Nutter		23B. DATE SIGNED 3/30/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Franklin Square Hospital		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/68		24C. NAME OF CEMETERY OR CREMATORY ARBUS MEMORIAL PK	
				24D. LOCATION Arbus Balto Co, MD	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR HERBERT E. NUTTER	
				ADDRESS 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-3780		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-3780	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Miss MARY REEDER		2. DATE AND HOUR OF DEATH 4-2-68 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		D. STREET ADDRESS (If rural, give location) 934 BENNETT PL.		E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH JULY 17, 1918	9. AGE (In years lost birth) 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTH PLACE (State or foreign country) BALTIMORE, MD	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME DELLIE REEDER		14. MOTHER'S MAIDEN NAME BESSIE GRAY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 218-36-5213		17. INFORMANT MRS. CATHERINE WILLIAMS		ADDRESS 2004 DUKELAND ST	
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH B. Hypertension A. Subarachnoid hemorrhage DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
330 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Erogenous Ectasy			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31/68 to 4/2/68 that (I) (we) last saw the deceased alive on 4/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. F. J. ZORICK M.D.		23B. DATE SIGNED 4-2-68			
23C. PHYSICIAN'S NAME (Type or Print) J. F. J. ZORICK M.D.		23D. ADDRESS Md. General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/6/68		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEM.	
24D. LOCATION BALTIMORE		24E. CITY, TOWN, or county MARYLAND		24F. STATE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968		25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR HERBERT E. NUTTER 3035 W. NORTH AVE	



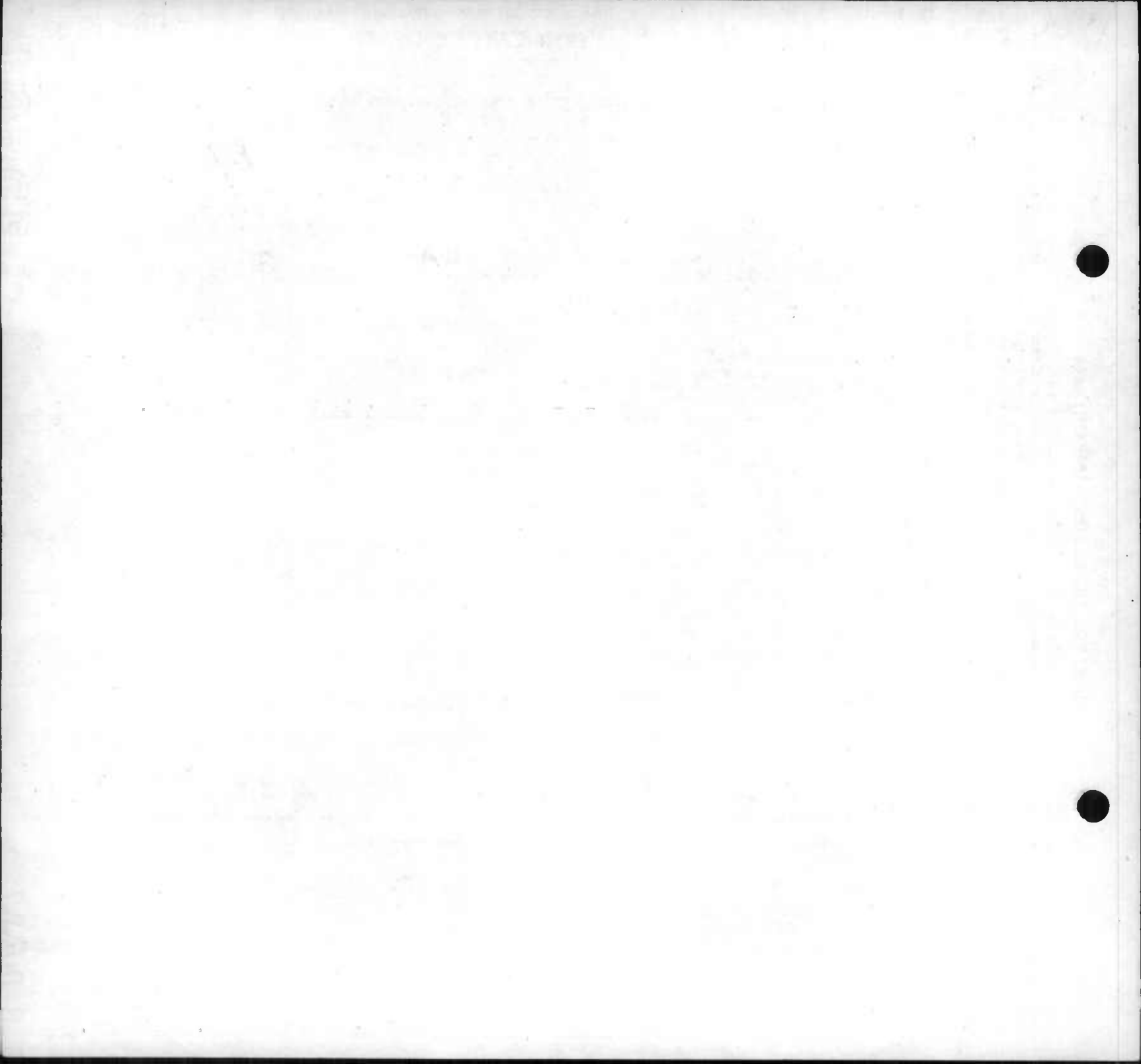
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 3781 CERTIFICATE OF DEATH

REG. NO. 68- 3781

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MINNIE DOLES</u>		2. DATE AND HOUR OF DEATH <u>April 4, 1968</u>   <u>10<sup>40</sup> A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>BALTIMORE</u> E. STREET AND NUMBER <u>1830 MADISON AVENUE</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/04</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE HITCH</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE Nutter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-30-4423</u>		17. INFORMANT ADDRESS <u>Mrs Ruth Cheeks 1830 Madison Ave.</u>	
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HAS CVD</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 10 days</u>	
19. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3 April</u> 19 <u>68</u> to <u>4 April</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>4 April</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jean M. Jackson, M.D.</u> OEGREE				23B. DATE SIGNED <u>4 April 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>JEAN M. JACKSON, M.D.</u> OEGREE				23D. ADDRESS <u>University of Maryland Hospital Balto, 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/7/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Family Lot</u>	
24D. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter 3035 W. North Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3782

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3782

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur Brown

2. DATE AND HOUR OF DEATH

4-4-68

5:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital  
1514 Division Street  
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3506 Cedardale Rd.

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

23  
7-22-91

9. AGE (In years last birthday)

76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Messenger

10B. KIND OF BUSINESS OR INDUSTRY

Internal Revenue

11. BIRTHPLACE (State or foreign country)

Baltimore County

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Benjamin F. Brown

14. MOTHER'S MAIDEN NAME

Arcena Scott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

WW-I

16. SOCIAL SECURITY NO.

220-05-1492

17. INFORMANT

ADDRESS

Mrs. Marie Armstrong 3506 Cedardale Rd

18. 431.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Hemorrhage

(C) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-24-68 19 to 4-4-68 19, that (I) (we) last saw the deceased alive on 4-4-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Certeza

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-4-68

23C. PHYSICIAN'S NAME (Type)

Dr. Certeza/ Dr. C. Laredo

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/8/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Spitzer

25C. FUNERAL DIRECTOR

Herbert E. Nutter

3035 W. North Ave

1. Center of the circle

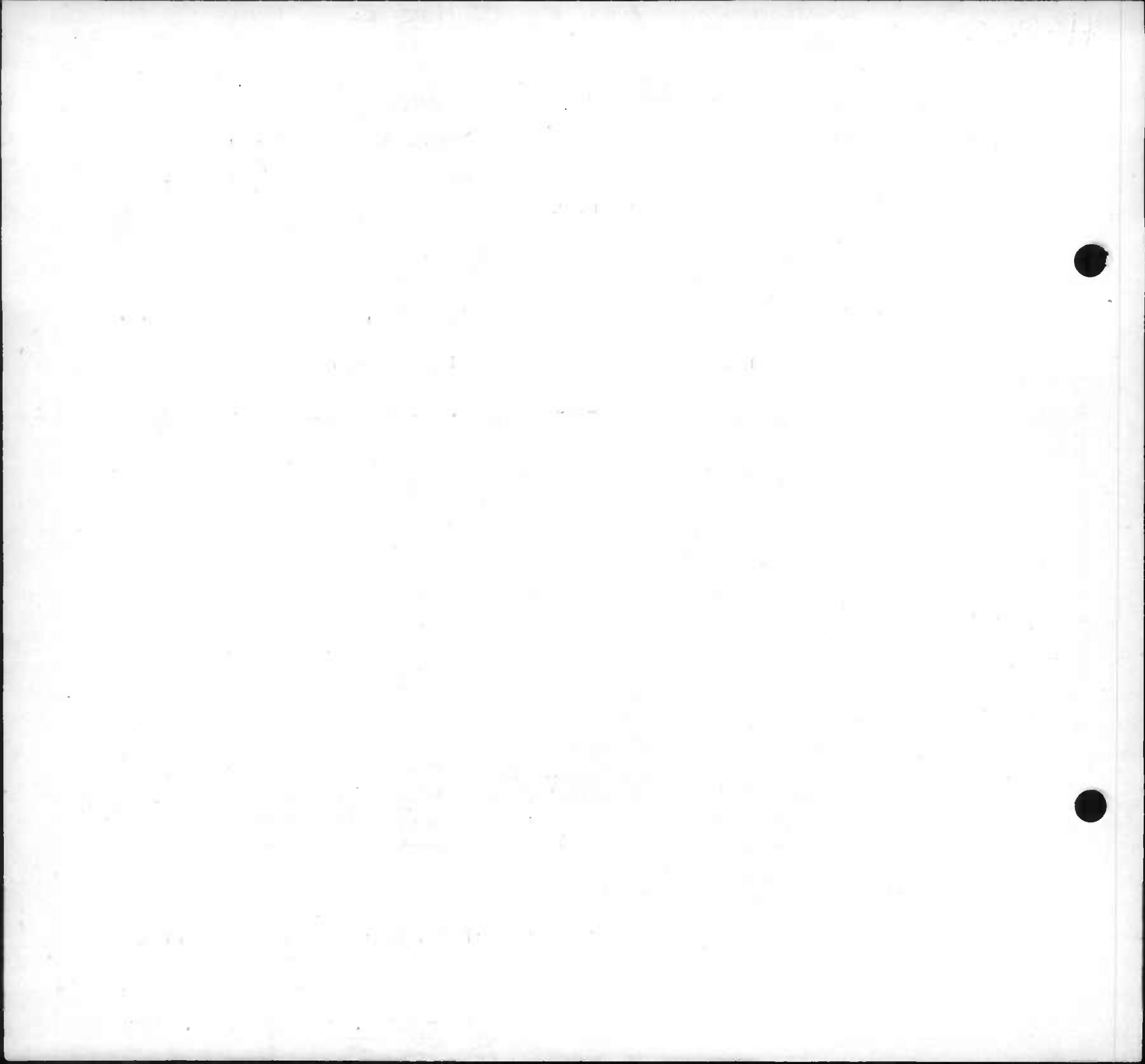
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT  
68- 3783 CERTIFICATE OF DEATH

REG. NO. 68- 3783

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PAULINE HOOD</b>		2. DATE AND HOUR OF DEATH <b>3-31-68 2 15 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> (Inside City Limits) <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1800 MADISON AVENUE</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/23/05</b>	9. AGE (in years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>		11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>ROULEY DANIEL</b>		
14. MOTHER'S MAIDEN NAME <b>IDA WRIGHT</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>220-30-2356</b>		17. INFORMANT <b>Mr. Edward Rowley</b> ADDRESS <b>1703 Ashburton Street</b>			
18. <b>412.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>8 hrs</b> (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: <b>10 yrs</b> (C) _____					
19. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <input type="checkbox"/> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-12</b> 19 <b>68</b> to <b>3-31</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3-31</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We, (did)) (did not) view the body after death.					
23A. SIGNATURE <b>J. V. Russo MD</b> DEGREE <b>MD</b>				23B. DATE SIGNED <b>3-31-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. V. Russo MD</b> DEGREE <b>MD</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Anne Arundel County, Md</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3035 W. North Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3784

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3784

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Ada B. Howard</b>		2. DATE AND HOUR OF DEATH <b>7 April 1968 9:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Lutherville</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER <b>19 Dennison St. Balto 21093</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02-10-00</b>	9. AGE (In years lost birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George W. Coombs</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Talbert</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/O</b>		16. SOCIAL SECURITY NO. <b>247-20-2804</b>		17. INFORMANT <b>Family Record</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Rabdo. 2 years</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>1979 II</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Miosarcoma</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>4-4-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intractable pain due to Rabdo Mio Sarcoma</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>03-27</b> 19 <b>68</b> to <b>4-7</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jorge Sabagal</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>JORGE SABAGAL MD.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-11-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Poplar Grove</b>	
24D. LOCATION <b>Baltimore Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Tanbarga</b>		25C. FUNERAL DIRECTOR <b>INM Cook-Brooks Towson-1050 York Rd Towson, Md.</b>			

Final report

Final report

Final report

Final report

Final report

Final report

Final report

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Final report

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Final report

Final report

Final report

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

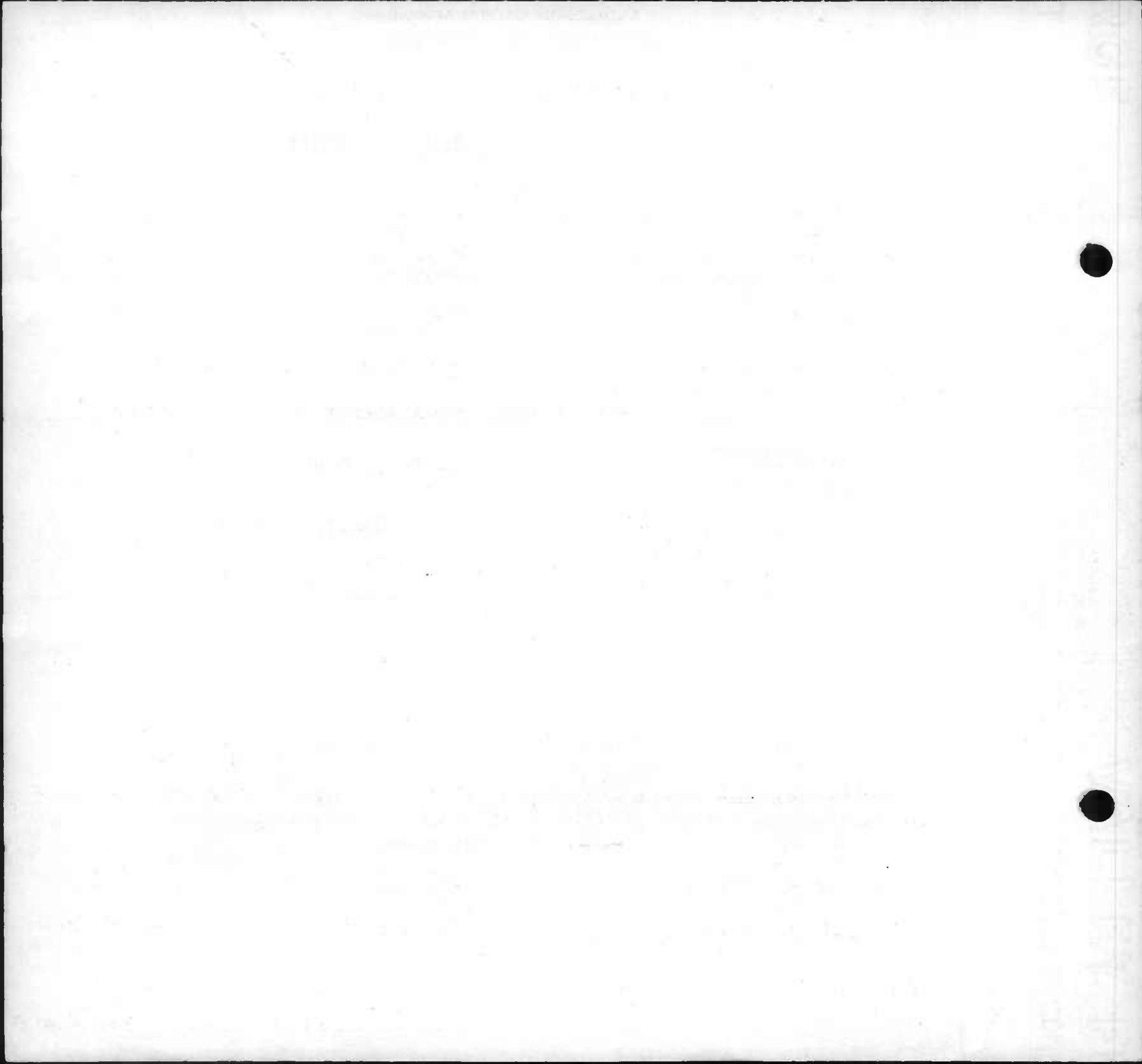
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3785	
BIRTH NO. <u>West Virginia</u> 68-3785		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>KERRY W. THOMAS</u>			2. DATE AND HOUR OF DEATH <u>4-8-68</u> <u>11</u> <u>10</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>			A. STATE <u>WEST VIRGINIA</u> B. COUNTY <u>V-45</u>		
C. CITY OR TOWN <u>SISSONVILLE</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>LEGG STAR RT BOX 407</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-62</u>	9. AGE (In years last birthday) <u>6</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY — — — — —	11. BIRTHPLACE (State or foreign country) <u>W VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>EMERY THOMAS</u>			14. MOTHER'S MAIDEN NAME <u>JEAN RANSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. — — — — —	17. INFORMANT ADDRESS <u>Johns Hopkins Hosp. Balto., Md</u>		
18. <u>753.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>electrolyte imbalances 8 days</u> <u>Multiple renal tubular defects congenital (salt losing)</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —		
19A. DATE OF OPERATION <u>757.3 II</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — — — — —		
20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No.</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — — — — —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — — — — —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — — — — —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? — — — — —	
22. I certify that (i) (this hospital) attended the deceased from <u>APRIL 5</u> 19 <u>68</u> to <u>APRIL 8</u> 19 <u>68</u> , that (i) (we) last saw the deceased alive on <u>APRIL 7</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William C. Maclean, Jr.</u> DEGREE				23B. DATE SIGNED <u>4-8-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MACLEAN, JR.</u> DEGREE				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>4-11-68</u>		24B. DATE <u>4-11-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>INDORAHILL CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>KANAWHA CO W VA.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farberma</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto., Md. 21202</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

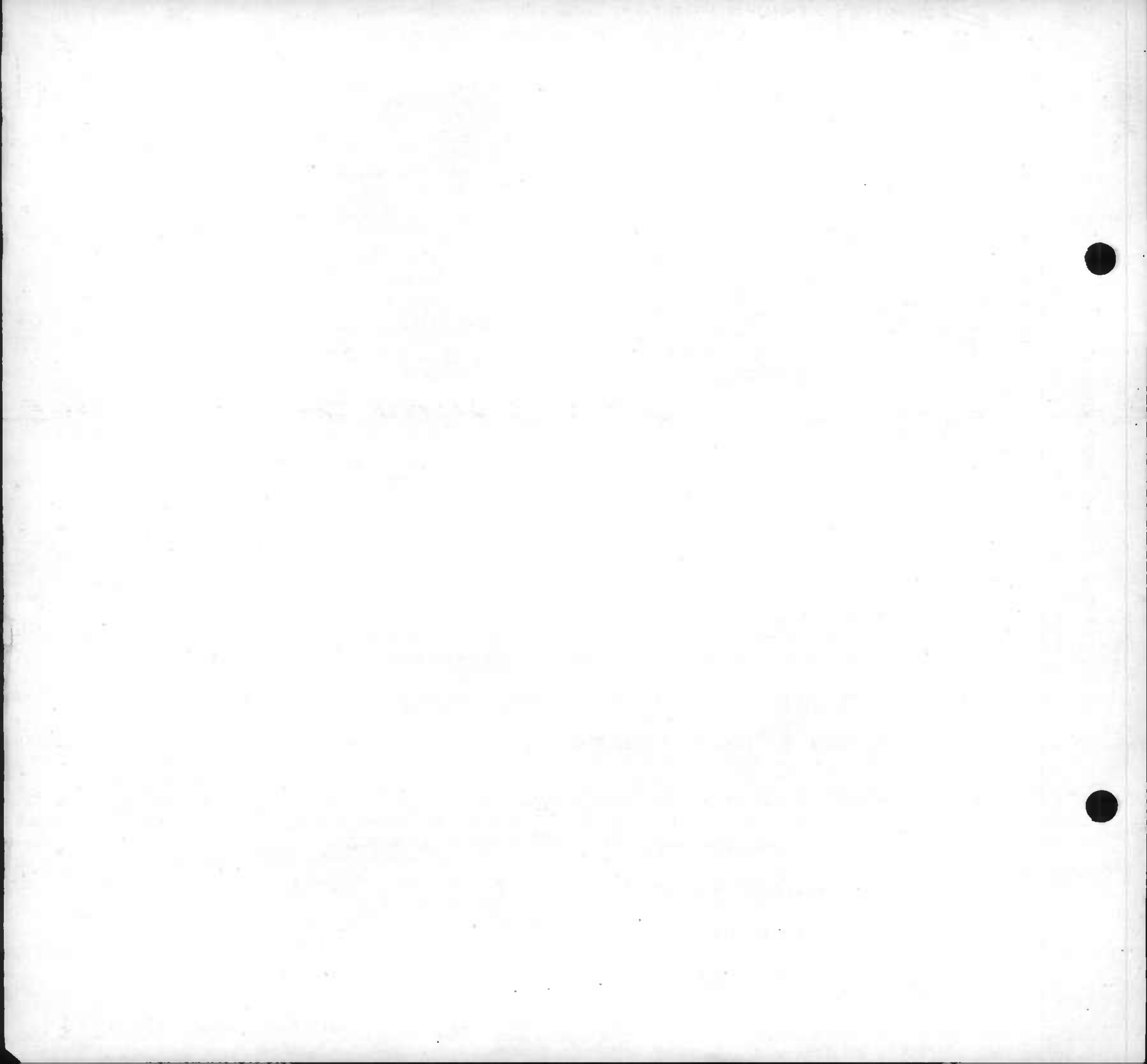
BALTIMORE CITY HEALTH DEPARTMENT									
D-256 68- 3786 CERTIFICATE OF DEATH					REG. NO. 68- 3786				
1. NAME OF DECEASED (Type or Print) <b>FLORENCE E. DASHNER</b>					2. DATE AND HOUR OF DEATH <b>APR. 5, 1968</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME HOSP</b>					A. STATE <b>MO.</b> B. COUNTY <b>BALTO.</b>				
					C. CITY OR TOWN <b>DUNDALK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <b>21 N. BRADFORD ST</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/31/97</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THEODORE COLLINS</b>					14. MOTHER'S MAIDEN NAME <b>CLARA PRITCHETT</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-05-9240</b>		17. INFORMANT <b>CHAS. DASNER</b>			
						ADDRESS <b>ABOVE</b>			
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Heart Failure</b> (C) <b>Diabetes mellitus</b>				
19. DATE OF OPERATION <b>260 X II</b>					20A. AUTOPSY? (Yes or No) <b>NO</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 1960</b> to <b>March 28 1968</b> , that (I) (we) last saw the deceased alive on <b>March 28 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <b>Manuel P. de Leon</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/5/68</b>		
23C. PHYSICIAN'S NAME (Type) <b>Manuel P. de Leon M.D.</b>					23D. ADDRESS <b>7840 Eastern Ave. Balt. Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>GARDENS OF FAITH</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>			ADDRESS <b>380 MACE</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

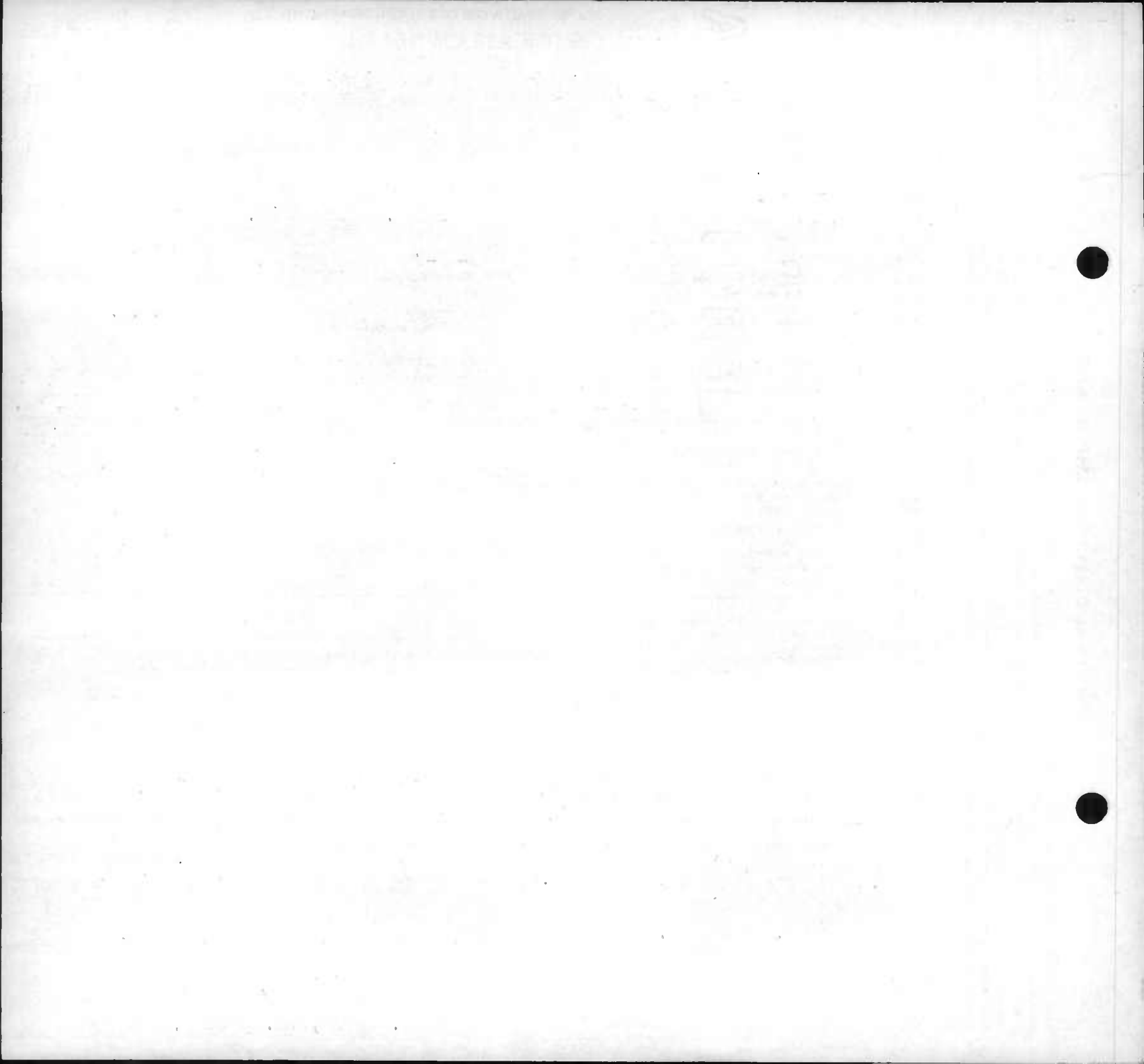
J-520		68- 3787		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3787	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>JANOWSKI, Dorothy JEAN</b>			
2. DATE AND HOUR OF DEATH <b>4-5-68</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>North Charles Gen. Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO CO</b>				5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>Box 106B Rte. 16 Middle River 21220</b>				9. AGE (In years last birthday) <b>32</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CHARLES EBBERTS</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH KUHN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-30-5124</b>			
17. INFORMANT <b>BERNARD JANOWSKI</b>				ADDRESS <b>ABOVE</b>			
18. <b>235.0 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenic, etc. It means the disease, injury or complication which caused death.) <b>BRAIN TUMOR</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>237 X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-3-68</b> to <b>4-5-68</b> , that (I) (we) last saw the deceased alive on <b>4-5-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>German de la Torre, MD</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>4-5-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>GERMAN DE LA TORRE, MD</b>						23D. ADDRESS <b>North Charles Gen. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLLY HILL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR <b>John J. Connelly Sons</b>		ADDRESS <b>Emmex 21</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200		68-3788		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3788	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>BOCK, Margaret</u>			
2. DATE AND HOUR OF DEATH <u>April 3, 1968</u> <u>1:00</u> P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>				5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland # 21224</u>			
E. STREET AND NUMBER <u>3113 E. Monument St. # 21224 007</u>				9. AGE (In years last birthday) <u>90</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Peter Seaman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Kistner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-44-2931</u>			
17. INFORMANT <u>BCH: Records 4940 Eastern Ave. Baltimore, Md.</u>				ADDRESS <u># 21224</u>			
18. <u>412.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>NO</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>March 8 1968</u> to <u>April 3 1968</u> , that (1) ( <del>was</del> ) lost saw the deceased alive on <u>did not see</u> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (1) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Raymond J. LaSure M.D.</u>				23B. DATE SIGNED <u>April 3, 1968</u>			
23C. PHYSICIAN'S NAME (Type) <u>Raymond J. LaSure MD.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Maryland # 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/8/68</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			
25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>				ADDRESS <u>3000 E. Baltimore St</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68- 3789

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr FRANK C. FELTER

2. DATE AND HOUR OF DEATH

4/9/68

12<sup>30</sup> A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MARYLAND General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

5923 BEETMAN AVE

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/8/99

9. AGE (In years last birthday)

68

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE Retired Oil Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John FELTER

14. MOTHER'S MAIDEN NAME

UNKNOWN.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214 014580

17. INFORMANT

SON M. FELTER

ADDRESS

Same

18. 451.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

± 1 wk.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Pulmonary Emboli

1-2 wks

(C) DUE TO, OR AS A CONSEQUENCE OF:

Thrombophlebitis, legs

several wks

463X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Cirrhosis of Liver

years

19A. DATE OF OPERATION

NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

NONE

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/2 19 68 to 4/9 19 68, that (I) (we) last saw the deceased alive on 4/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. J. Zorick

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/9/68

23C. PHYSICIAN'S NAME (Type)

F. J. ZORICK M.D.

23D. ADDRESS

MD. Gen'l. Hosp. Balto MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/12/68

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

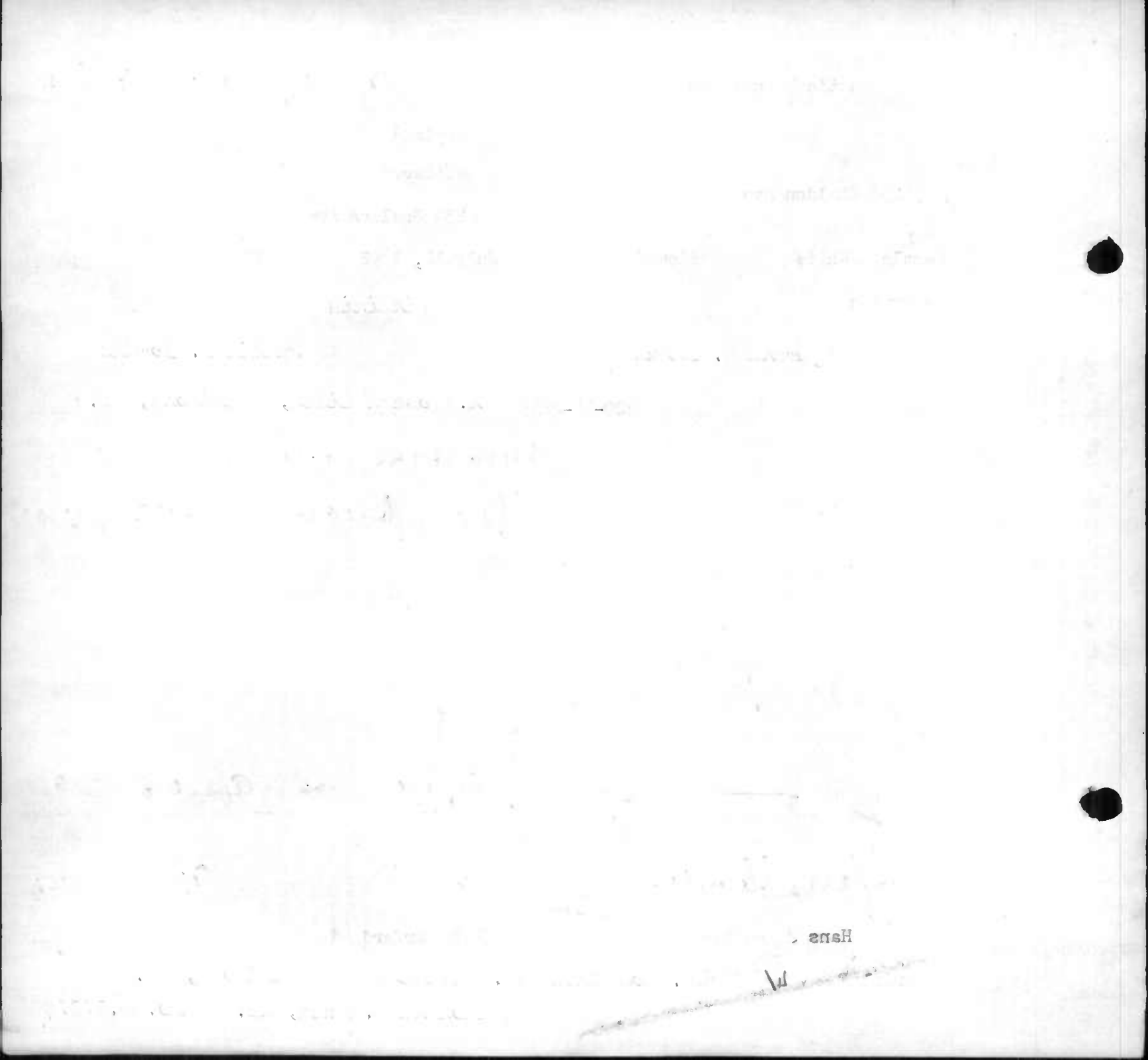
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 68-3790		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 68-3790	
1. NAME OF DECEASED (Type or Print) <b>Nettie W Hamilton</b>			2. DATE AND HOUR OF DEATH <b>April 8, 1968   6:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4238 Sheldon Ave</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4238 Sheldon Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 12, 1892</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Edward A. Strum</b>			14. MOTHER'S MAIDEN NAME <b>Pattie S. Fowlks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-111-2215</b>		17. INFORMANT ADDRESS <b>Mr. Joseph Liter, Baltimore, Md.</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>from breast</b>			INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>April 3rd 1968</b> to <b>April 8 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 3rd 1968</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Hans J Koetter</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>April 8, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>Hans J Koetter</b>			23D. ADDRESS M.D. <b>5600 Harford Rd</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3791

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <i>Albrecht</i> <i>Louis H. Albrecht</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Johns Hopkins Hospital</i>		3. DATE PRONOUNCED DEAD <i>April 7, 1968</i>		Month	Day	Year	Hour	M.
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>7-02</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
6. SEX <i>Male</i>	7. RACE <i>White</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER <i>2412 E. Madison St.</i>				
9. DATE OF BIRTH <i>Dec. 1, 1911.</i>		10. AGE (In years last birthday) <i>56</i>		11. BIRTHPLACE (State or foreign country) <i>Massachusetts N. Y.</i>				
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Hugo Albrecht</i>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Interior Decorator</i>				
15. MOTHER'S MAIDEN NAME <i>Unknown</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 2</i>		17. SOCIAL SECURITY NO. <i>215-01-8908</i>		18. INFORMANT ADDRESS <i>Mrs. Charles S. Ely, Ellicott City, Md.</i>		
19. <i>E968 X-303.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <i>E983 X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>Carbon monoxide</i> DUE TO, OR AS A CONSEQUENCE OF:  (C) <i>Conflagration</i>  <i>Acute ethylism</i> <del><i>Conflagration</i></del>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <i>0</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					21. AUTOPSY? (Yes or No) <i>No</i>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>house</i>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <i>2054 E. Federal Street</i>				
22D. TIME OF INJURY (APPROX.) <i>4-6-68 11:05 P.m.</i>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <i>Found in burning building on 1st floor</i>				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> <del>Accident</del> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type) <i>Russell S. Fisher, M.D.</i>  CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>April 7, 1968</i>								
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/10/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1968</i>		25B. NAME OF REGISTRAR <i>R. E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>				

4/29/68 - Letter from Dr. Russell Ficker, Chief  
Indians Examiner dated 4/29/68. JFC.  
5/3/68 - 2nd letter " " 4/30/68 JFC.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

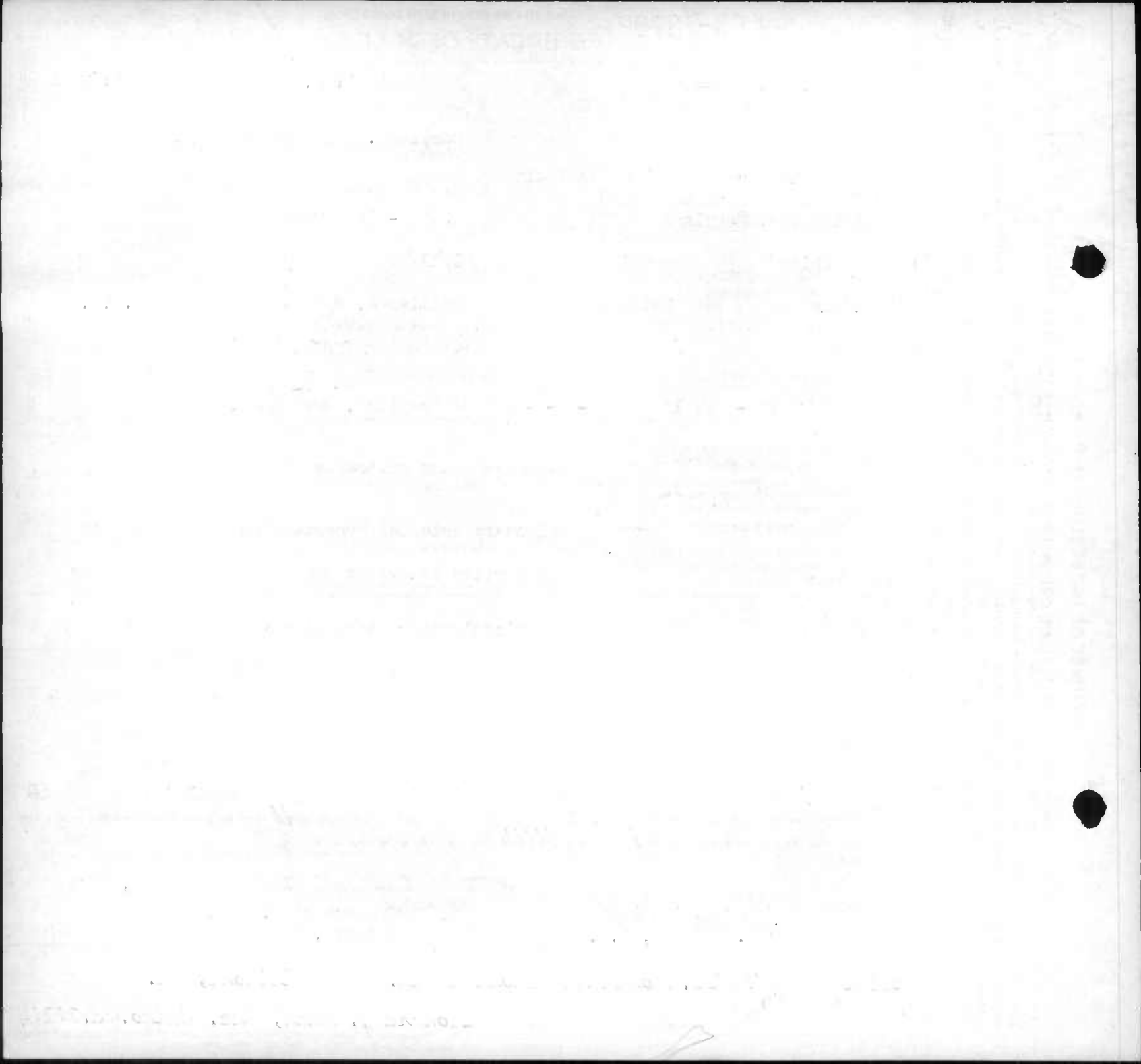
68- 3792

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO.

68- 3792

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SHEA, John Thomas</b>		2. DATE AND HOUR OF DEATH <b>April 8, 1968</b> <b>3:50 A</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY <b>21234</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			C. CITY OR TOWN <b>Carney</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Male</b> 6. RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/11/89</b> 9. AGE (In years last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroadman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>John Shea</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Treadwell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5/28/18 - 6/7/19</b>		16. SOCIAL SECURITY NO. <b>218-12-0909</b>		17. INFORMANT <b>Records</b> ADDRESS <b>VA Hospital, Baltimore, Md 21218</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>527.1 II</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Pulmonary arterial hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Obstructive emphysema</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 year</b> <b>20 years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic heart disease</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 11</b> 19 <b>67</b> to <b>April 8th</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 8th</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ralph H. Twining</b> DEGREE				23B. DATE SIGNED <b>April 8, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>RALPH H. TWINING, M.D.</b> DEGREE				23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Sweeney</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			



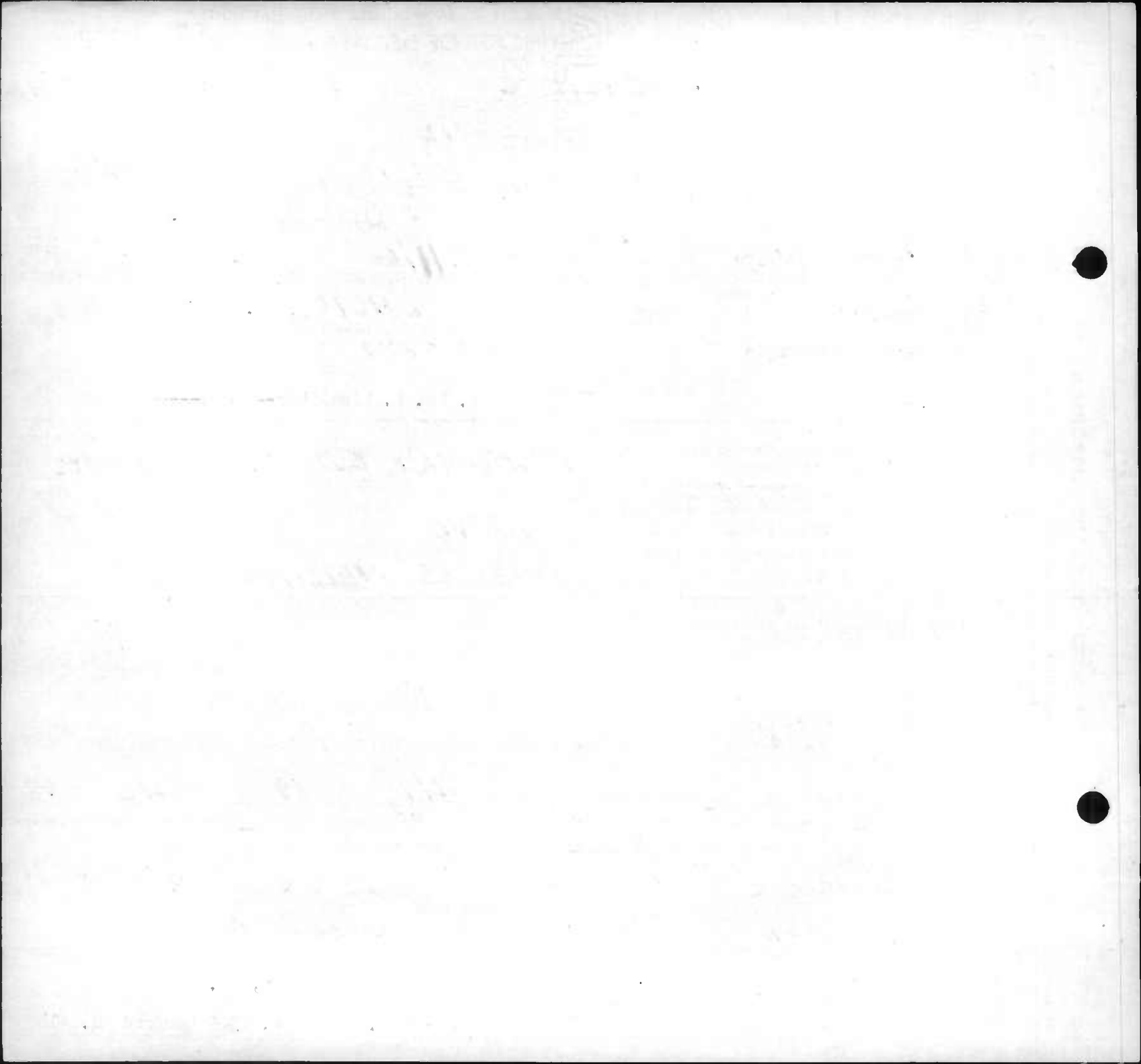
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3793

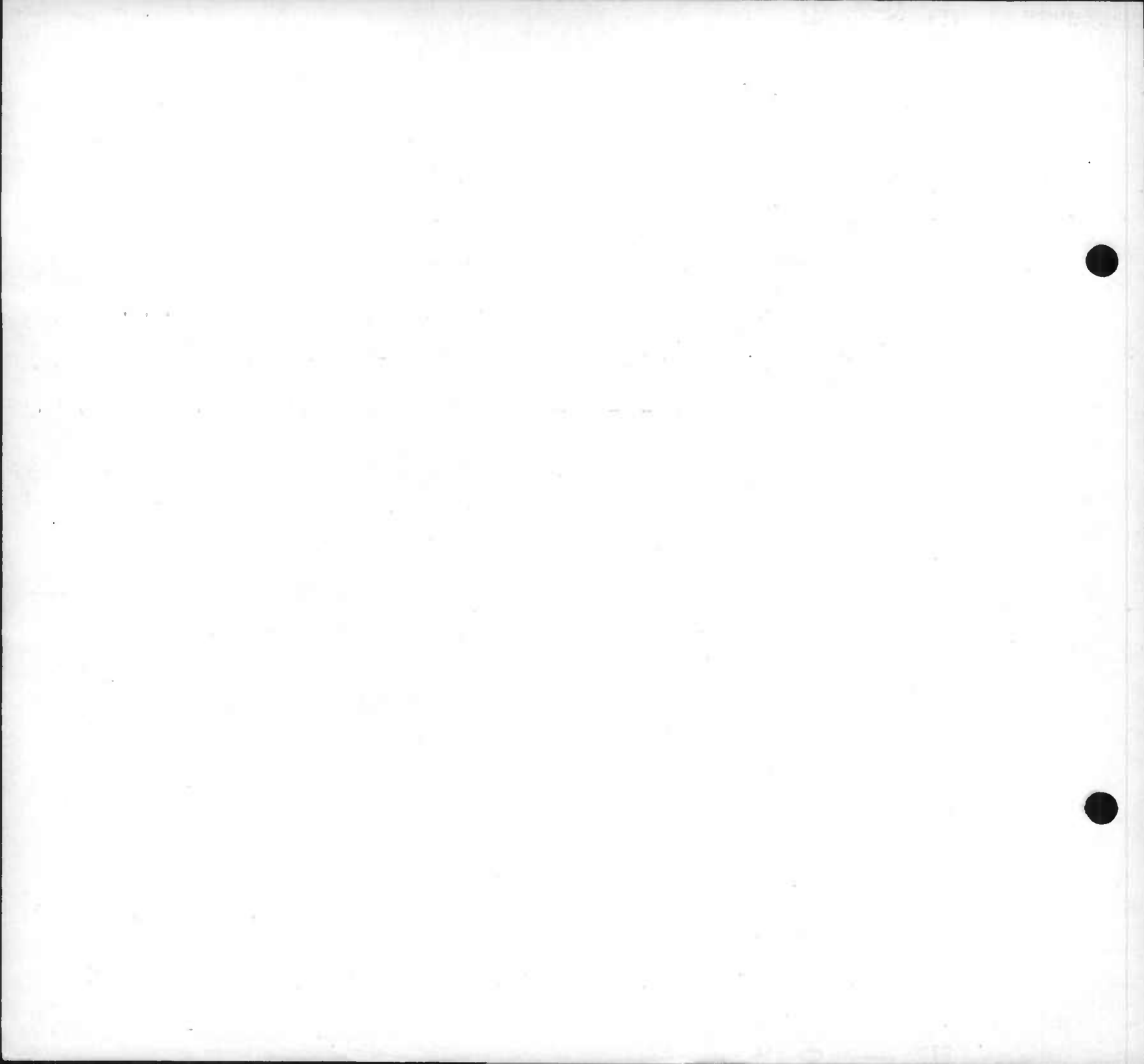
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BETTY LICHLITER</b>		2. DATE AND HOUR OF DEATH <b>4/5/68 6:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP OF BALTO.</b>			C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1621 GORSUCH AVE.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/18/06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>George Spitznagle</b>			14. MOTHER'S MAIDEN NAME <b>Anna Quaty</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Wm. L. Lichliter-- Same-----</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EDEMA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>DIABETES MELLITUS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/1</b> 19 <b>68</b> to <b>4/5</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/5</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward R. Cohen, MD</b> OEGREE				23B. DATE SIGNED <b>4/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD R. COHEN</b> OEGREE				23D. ADDRESS <b>Sinai Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/18/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 5 1968</b>		25B. NAME OF REGISTRAR <b>John E. [unclear]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. 5305 Harford Rd. #14</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Harry E. Finch</b>		2. DATE AND HOUR OF DEATH <b>4/6/68 6:45 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> 4940 Eastern Ave. Baltimore, Maryland # 21224				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER <b>3981 Sinclair Lane</b> 21213 007	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewery Worker (Ret)</b>				9. AGE (In years last birthday) <b>70</b>	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William W. Finch</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-01-9271-A</b>	
17. INFORMANT <b>BCH; Records</b>				ADDRESS <b># 21224 4940 Eastern Ave. Baltimore, Md.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Route myocardial infarction 28 days &amp; 4 days</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>COPD, pneumonia</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>68</b> to <b>4/6</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ed Rupp</b>				23B. DATE SIGNED <b>4/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>LEONARD LIPPYAN, MD</b>				23D. ADDRESS <b>4940 Eastern Ave. Baltimore, Maryland BALT. CITY HOSPITALS # 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Baltimore Md.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		24E. STATE (State)			
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tarkenton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Rupp, Inc 5305 Hartford Rd.</b>	



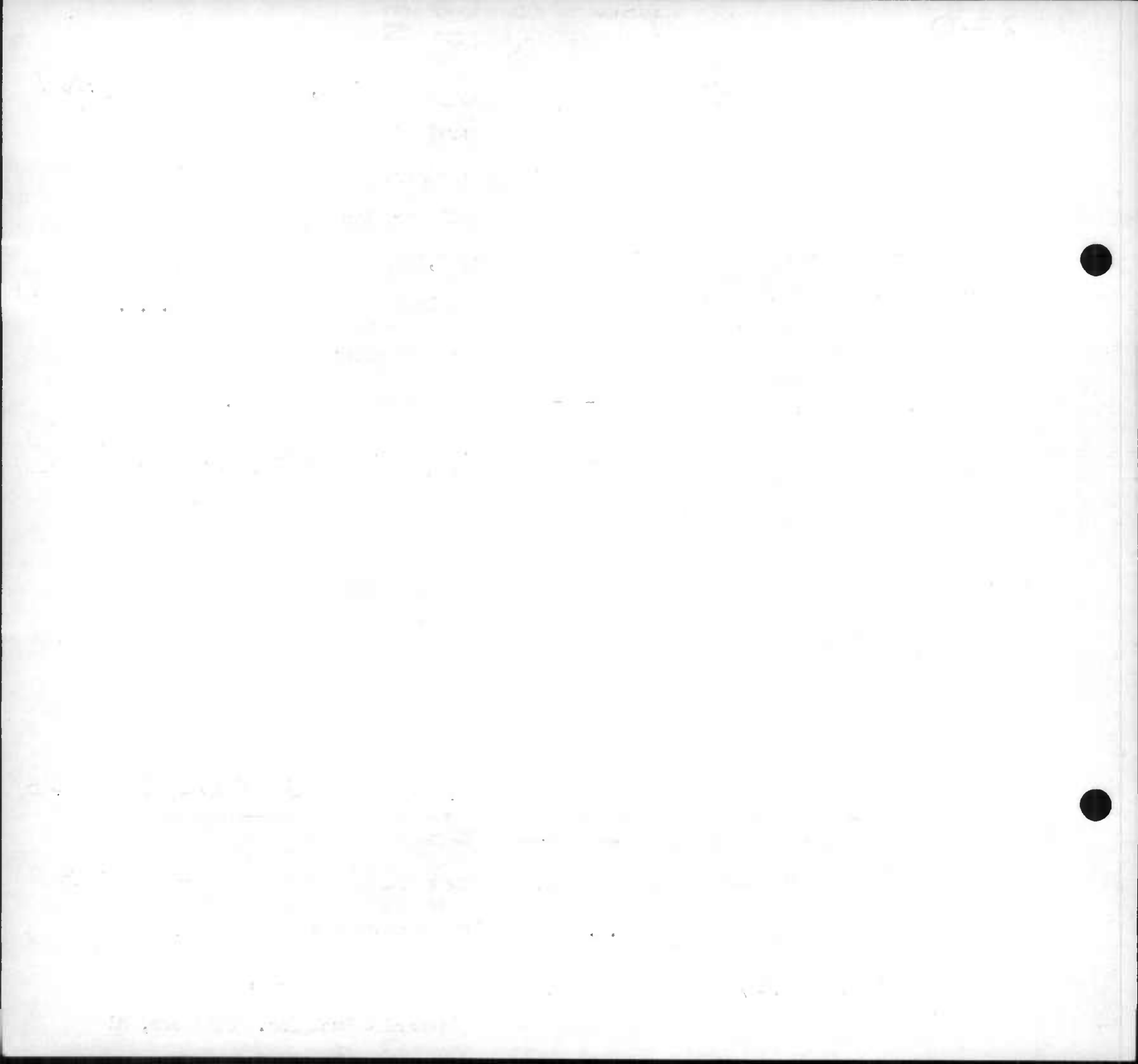
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3795

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3795

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Magdalen J Wojcik</b>		2. DATE AND HOUR OF DEATH <b>April 6, 1968</b> <b>5:10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>4411 Mary Ave</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>May 2, 1879</b>	
13. FATHER'S NAME <b>John Poffel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Klosicki</b>		9. AGE (In years last birthday) <b>88</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-46-0606</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
17. INFORMANT <b>Mrs Stella M Prouty</b>		ADDRESS <b>Same</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. <b>412.7 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>10 YEARS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YEARS</b>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1965</b> to <b>APRIL 6 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 3 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert C Herrmann M.D.</b>				23B. DATE SIGNED <b>4/7/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Albert C Herrmann M.D.</b>				23D. ADDRESS <b>4420 Manasota Ave Baltimore, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>	
24D. LOCATION <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3796

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Winfield S. Canby Sr.</i>		2. DATE AND HOUR OF DEATH <i>April 4, 1968</i>   <i>10<sup>20</sup></i> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		5. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bel Aire House in the Pines</i> <i>5837 Belair Road</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>5610 Anthony Avenue</i>	
6. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 15, 1890</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Md. Rail Road</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Winfield S. Canby</i>		14. MOTHER'S MAIDEN NAME <i>Annie Affreau</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-10-4198</i>		17. INFORMANT ADDRESS <i>Mrs. Mary Pfaff 6860 Sturbridge Dr. 34</i>	
18. <i>412.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Crown heart disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>	
19. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1956</i> to <i>April 4, 1968</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>April 1, 1968</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <i>R Donald Jandorf</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4-5-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>R Donald Jandorf</i>		23D. ADDRESS <i>6077 Harford Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-8-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>APR 9 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Tarkenton</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc Baltimore, Md.</i>			

Very best

Donald + wife  
April 1 1880

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3797

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3797

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CONNOLLY MRS CHRISTINE E

2. DATE AND HOUR OF DEATH

4 - 6 - 1968 3-25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

2804 CLEARVIEW AV.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-8-28 90

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOME MAKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael  
ANDREW RYAN

14. MOTHER'S MAIDEN NAME

MARGARET MC COURT

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-28-7040

17. INFORMANT

ADDRESS

William I Connolly 6607 Walther Ave

18. 4-12-9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) A SCOP

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4-22-1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Pneumonia; Chronic Renal Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4 - 2 - 1968 to 4 - 6 - 1968,  
that (I) (we) last saw the deceased alive on 4 - 6 - 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Rodolfo M. Lina

OEGREE

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

4-6-68

23C. PHYSICIAN'S  
NAME (Type)

Rodolfo M. Lina

OEGREE

23D. ADDRESS

CHH

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/9/68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 9 1968

Robert E. Finkbeiner

Leonard J Ruck Inc. Baltimore, Md.

CHRISTINE

HAWAII

1947

CHARLES H. HARRIS HOSPITAL

8804 CLARKSON HWY.

P-35-11

F M

HOMER HARRIS

ANDREW RYAN

MD

MARGARET M. HARRIS

Myrtlewood, Hawaii

P-35-11

Myrtlewood, Hawaii

P-35-11

P-35-11

Myrtlewood, Hawaii

Myrtlewood, Hawaii

Myrtlewood, Hawaii

FUNERAL DIRECTOR: IMPORTANT

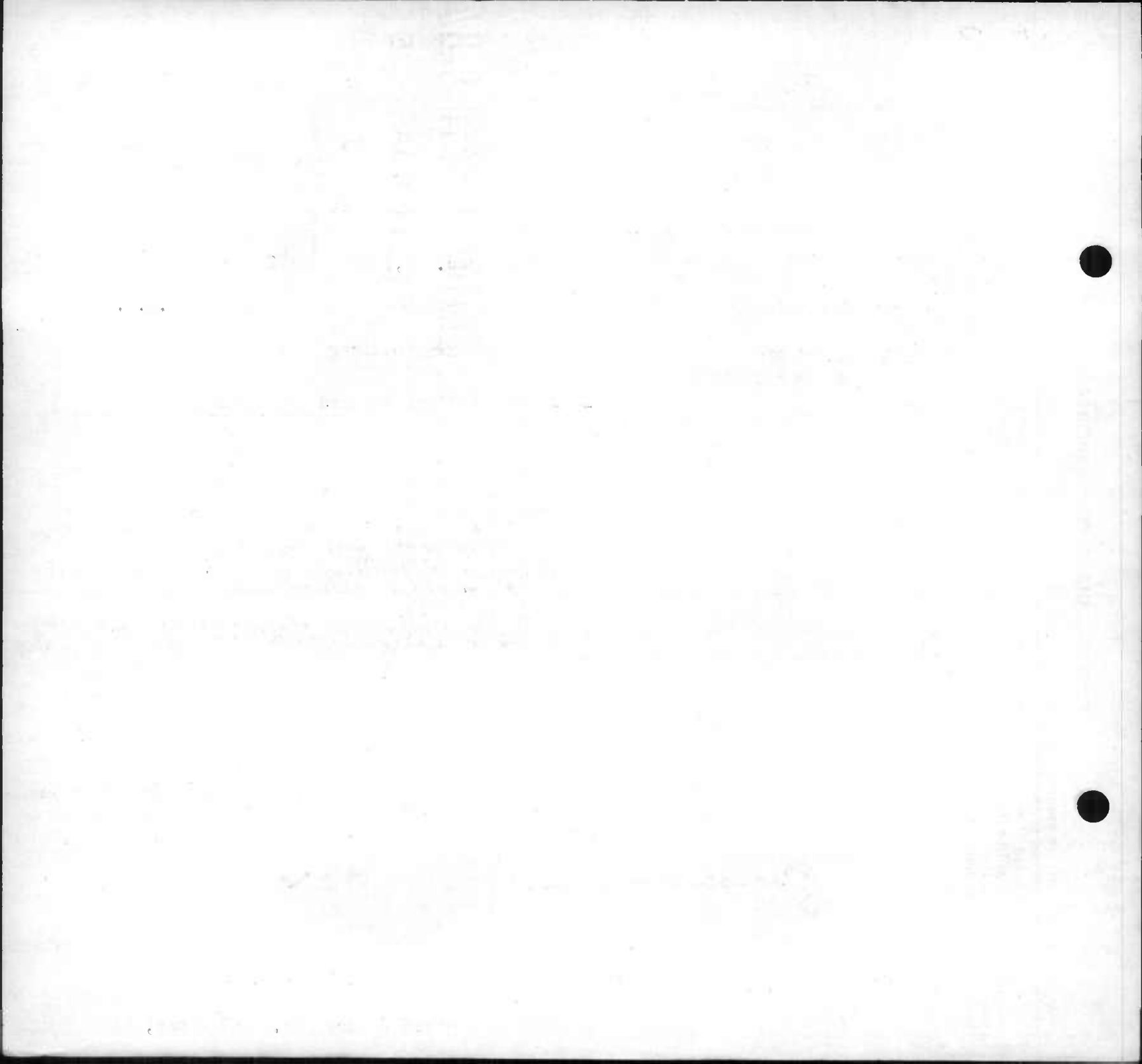
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3798

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3798

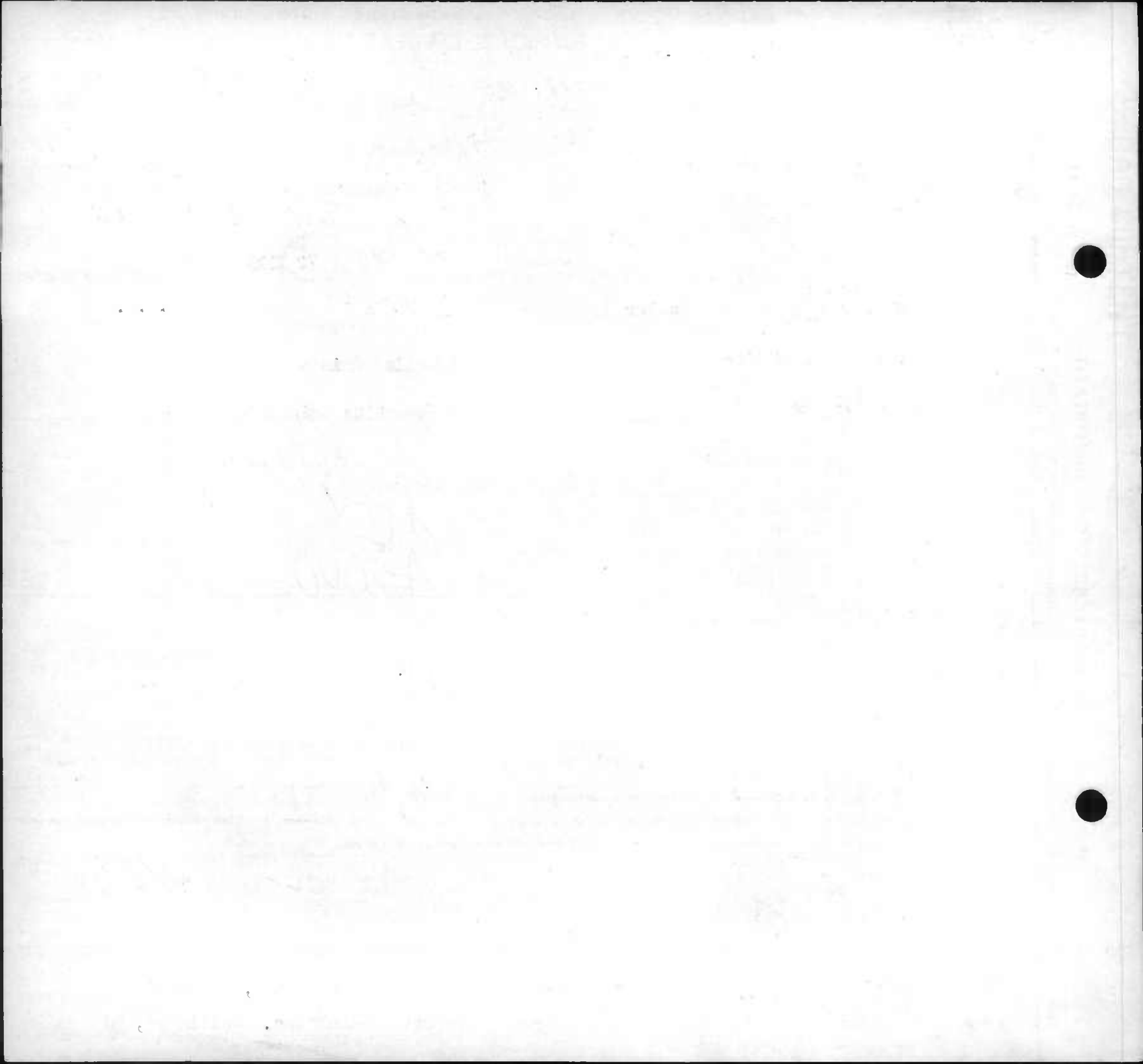
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PAUL LEONARD</b>		2. DATE AND HOUR OF DEATH <b>4-5-68</b>		7 <sup>25</sup> <sub>P.</sub> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1045 Hillen St</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 22, 1895</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sign Painter</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Paul Leonard Sr</b>			
14. MOTHER'S MAIDEN NAME <b>Eva Roediger</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-16-6108</b>				17. INFORMANT <b>Lillian Leonard</b> Same			
18. <b>433.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>respiratory arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>old CVS w/ prob. recent one on (1)</b> <b>&gt; 3 days</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: prob. thrombosis</b> <b>(C) polycythemia w/ to clt. abd. airway d. sw. years</b> <b>332X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>some aged. dehydration thrombocytosis</b> <b>&lt; 2 days</b>							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4:30 PM April 3 19 68</b> to <b>7:25 PM April 5 19 68</b> , that (I) (we) last saw the deceased alive on <b>7:25 PM April 5 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Grance</b>				23B. DATE SIGNED <b>4-6-68</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>DEGREE</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>4/8/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3799				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3799	
CERTIFICATE OF DEATH							
BIRTH NO.		Angelo Mingilino		2. DATE AND HOUR OF DEATH		4/6/68 2:30A M.	
1. NAME OF DECEASED (Type or Print)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
425 MAI HOSPITAL OF BALTIMORE INC				Balto		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				6216 The Alameda			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/30/96	72			
10A. USUAL OCCUPATION (Give kind of work done during most of life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired UNKNOWN				Tailor		ITALY	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Anthony Mingilino				Carmella Gusta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mrs Josephine Mingilino Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				Asythemic			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				MI			
420.1 II				ASLUD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (H) (this hospital) attended the deceased from 4/6 2:30AM 4/6 19 68 to 4/6 19 68 that (H) (we) last saw the deceased alive on 4/6 19 68 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
ASLUSHAKOV						4/6/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ASLUSHAKOV							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/9/68		Sacred Heart		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 9 1968		Robert E. Taylor		Leonard J Ruck Inc.		Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 3800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-- 3800

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James M Fesmire

2. DATE AND HOUR OF DEATH

April 6, 1968

4:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Gould Convalesarium

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2716 Kildaire Drive

5. SEX

male

6. RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 25, 1889

9. AGE (In years  
last birthday)

78

If Under 1 Yr.  
Months: Days

If Under 24 Hrs.  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done even if retired)

Retired Capt.  
Maritime Service

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Wesley Fesmire

14. MOTHER'S MAIDEN NAME

Margaret Mahoney

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-03-7345

17. INFORMANT

Mrs Sophia T Fesmire

ADDRESS

Same

18.

250.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE Coronary artery disease  
DUE TO, OR AS A CONSEQUENCE OF:

2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) Diabetes mellitus  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

MEDICAL CERTIFICATION

260X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1947 to April 6, 1968,  
that (I) (~~we~~) last saw the deceased alive on April 3, 1968 and that in (my) (~~our~~) opinion death occurred on the date  
and hour and from the causes stated above. (I) (~~we~~) (~~did~~) view the body after death.

23A. SIGNATURE

Ronald Jandorf

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

4-6-68

23C. PHYSICIAN'S  
NAME (Type)

R Donald Jandorf

23D. ADDRESS

6077 Harford Rd Balto Md

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/9/68

24C. NAME OF CEMETERY or CREMATORY

Dulaney Valley

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

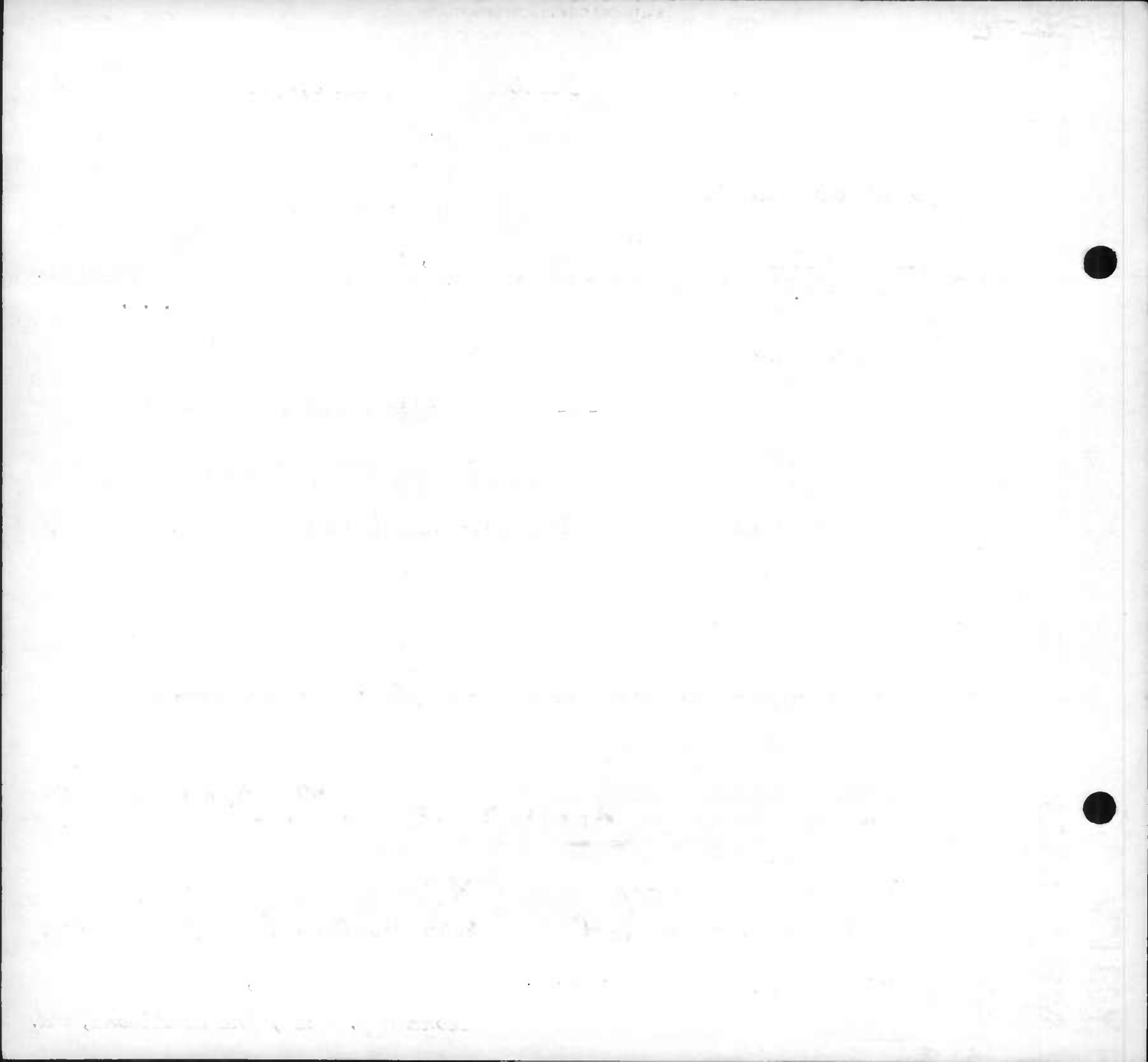
25B. NAME OF REGISTRAR

Robert E. Fesmire

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc Baltimore, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

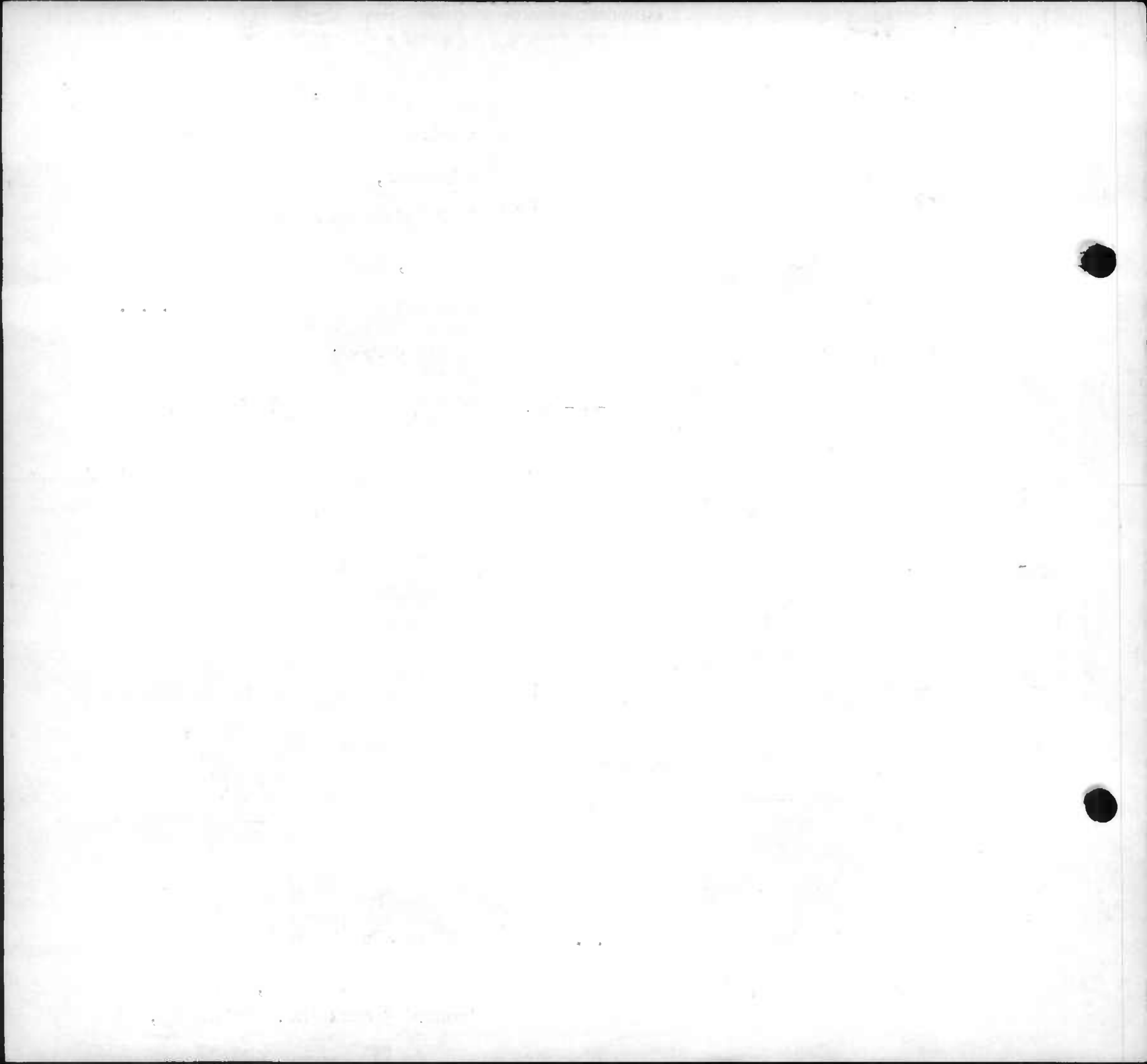
68-- 3801

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-- 3801

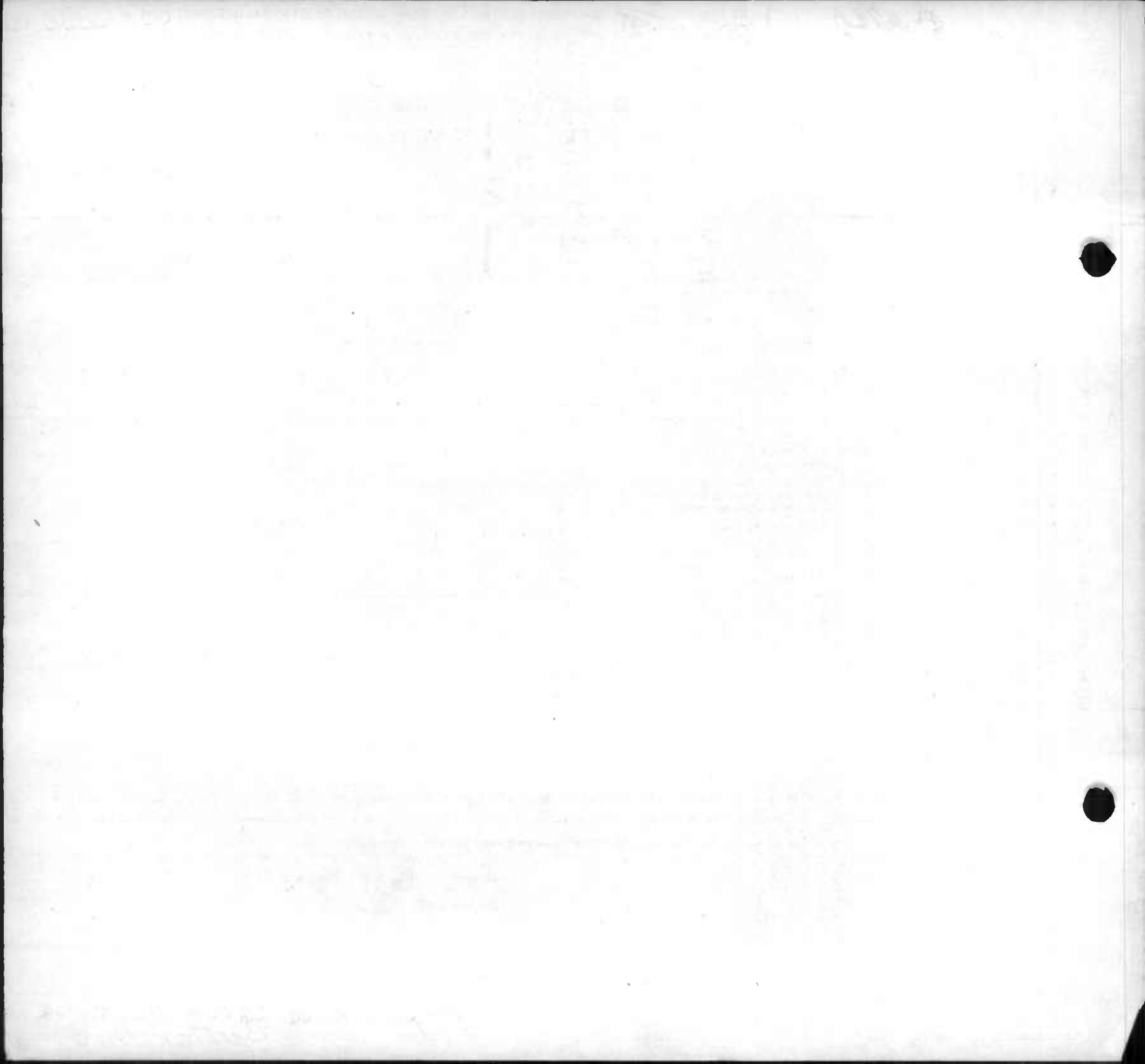
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret E Klein</b>		2. DATE AND HOUR OF DEATH <b>April 7, 1968</b> <b>8<sup>00</sup> A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Nursing Home</b> <b>90</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore,</b> D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>26-03</b> E. STREET AND NUMBER <b>3512 Clifmont Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1897</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John F Slaine</b>			14. MOTHER'S MAIDEN NAME <b>Annie M Myers</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-2622</b>		17. INFORMANT <b>John F Klein Sr</b> ADDRESS <b>3512 Clifmont Ave</b>	
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Brachy pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>					
19. <b>491X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>arterio-sclerotic Heart Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 8</b> 19 <b>66</b> to <b>April 7</b> 19 <b>68</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 5</b> 19 <b>68</b> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>do</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Stanley Z Felsenberg M.D.</b>				23B. DATE SIGNED <b>4/8/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Stanley Z Felsenberg M.D.</b>				23D. ADDRESS <b>1129 East Baltimore St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Most Holy Redeemer</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Felsberg</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-642		68-3802		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 2049283802	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CHARLES RUFUS D.			
2. DATE AND HOUR OF DEATH 4/6/68				8-09 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTO.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6/9/04		9. AGE (In years last birthday) 63.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ground keeper				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Maryland	
13. FATHER'S NAME Daniel Charles				14. MOTHER'S MAIDEN NAME Susanne Ward			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-30-7414		17. INFORMANT Dr. J. Pradhan M.D. Sinai Hospital	
18. CAUSE OF DEATH 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoxia (B) PNEUMOTHORAX & PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA OESOPHAGUS			
MEDICAL CERTIFICATION 150X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pt. to breathe		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from 4/3 1968 to 4/6 1968, that (I) (we) lost saw the deceased alive on 4/6/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. D. J. Pradhan						23B. DATE SIGNED 4/6/68	
23C. PHYSICIAN'S NAME (Type) DR. D. J. PRADHAN						23D. ADDRESS SINAI HOSPITAL OF BALTO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 10, 1968		24C. NAME OF CEMETERY or CREMATORY St. Lukes Cemetery		24D. LOCATION (City, town, or county) (State) Reisterstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph L. Rivers		25D. ADDRESS 2222 W. North Ave Baltimore, Md	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3803

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WARREN J. (AKA) Prestley PREISTLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 8, 1968</b>		Hour <b>6:10 A</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PARKING LOT GREYHOUND BUS TERMINAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 8, 1968</b>		Hour <b>6:10 A</b>
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>Nov. 4, 1908</b>		10. AGE (In years lost birthday) <b>59</b>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Sunter, S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>1617 St. Stephen Way</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Prisoner</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Dry cleaners</b>		15. MOTHER'S MAIDEN NAME <b>Isabella Holiday</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>212-10-1110</b>		18. INFORMANT ADDRESS <b>Mrs. Bertha Prestley 1617 St. Stephens St.</b>
19. <b>412.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>422.1 II</b>				
20A. DATE OF OPERATION <b>4-8-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>4-8-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 10, 1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>
24D. LOCATION <b>5501 Fred. Ave.</b>		24E. (City, town, or county) <b>Baltimore, Md.</b>		24F. (State) <b>Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph L. Russ 2222 N. North Ave Baltimore, Md</b>



M-460

68- 3804

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3804

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary M. Mueller

2. DATE AND HOUR OF DEATH

April 7, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

HOOD NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

N

E. STREET AND NUMBER

5208 Norwood Avenue # 21207

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6-12-1889

9. AGE (In years  
last birthday)

78

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-10-6379D

17. INFORMANT

William H. Mueller-5208 Norwood Avenue

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 yrs.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Generalized Arterio Sclerosis.

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from July - 19 - 1968 to April 7 - 1968.  
that (I) last saw the deceased alive on April - 4 - 1968 and that in (my) opinion death occurred on the date  
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

Earl L. Chambers M.D.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

4/8/68

23C. PHYSICIAN'S  
NAME (Type)

Earl L. Chambers - M.D.

DEGREE

23D. ADDRESS

4108 Liberty Hts. Balto - Ind

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-9-68

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Ellsworth Armacost 4600 Liberty Hghts,

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

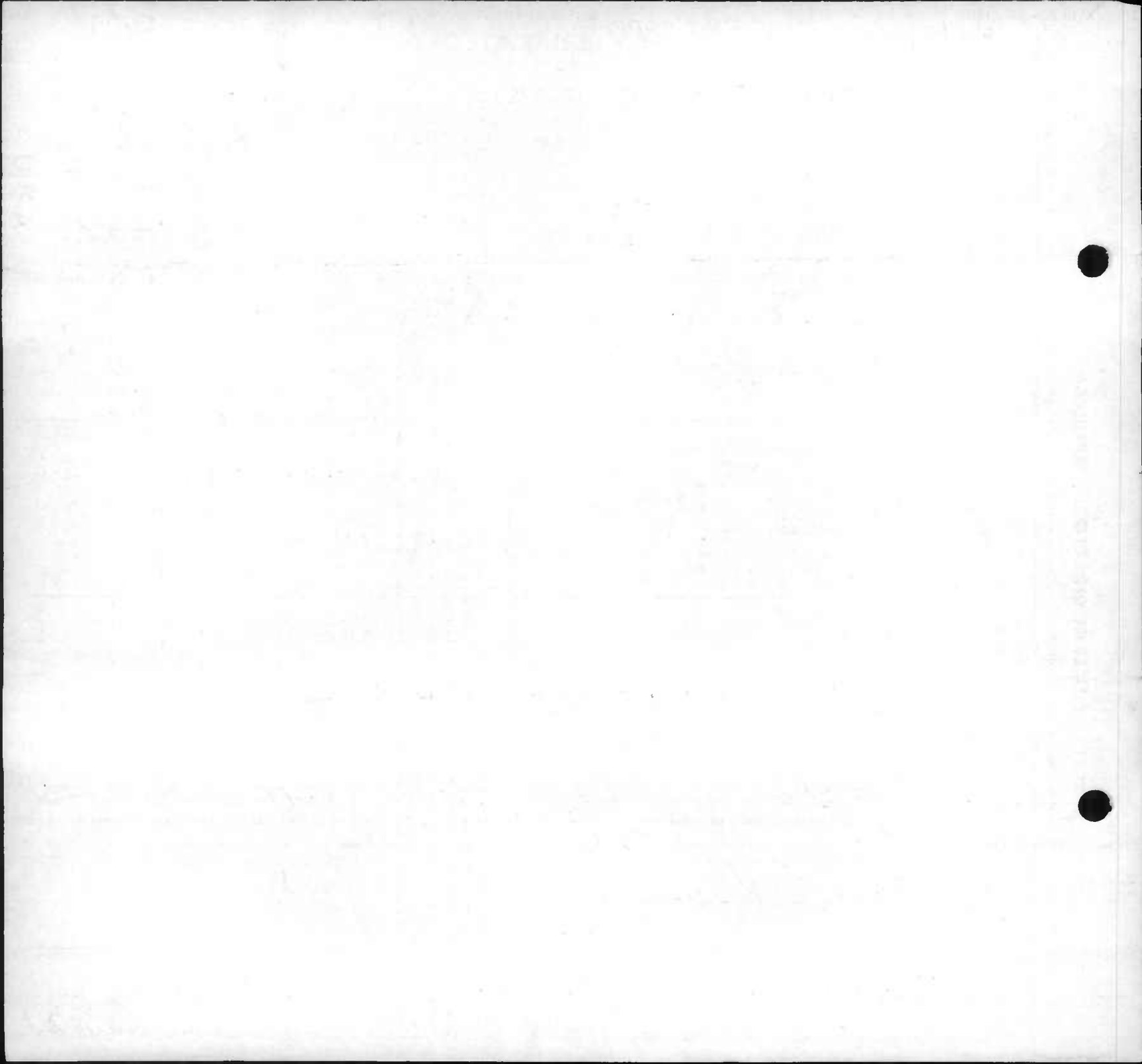
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3805

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3805

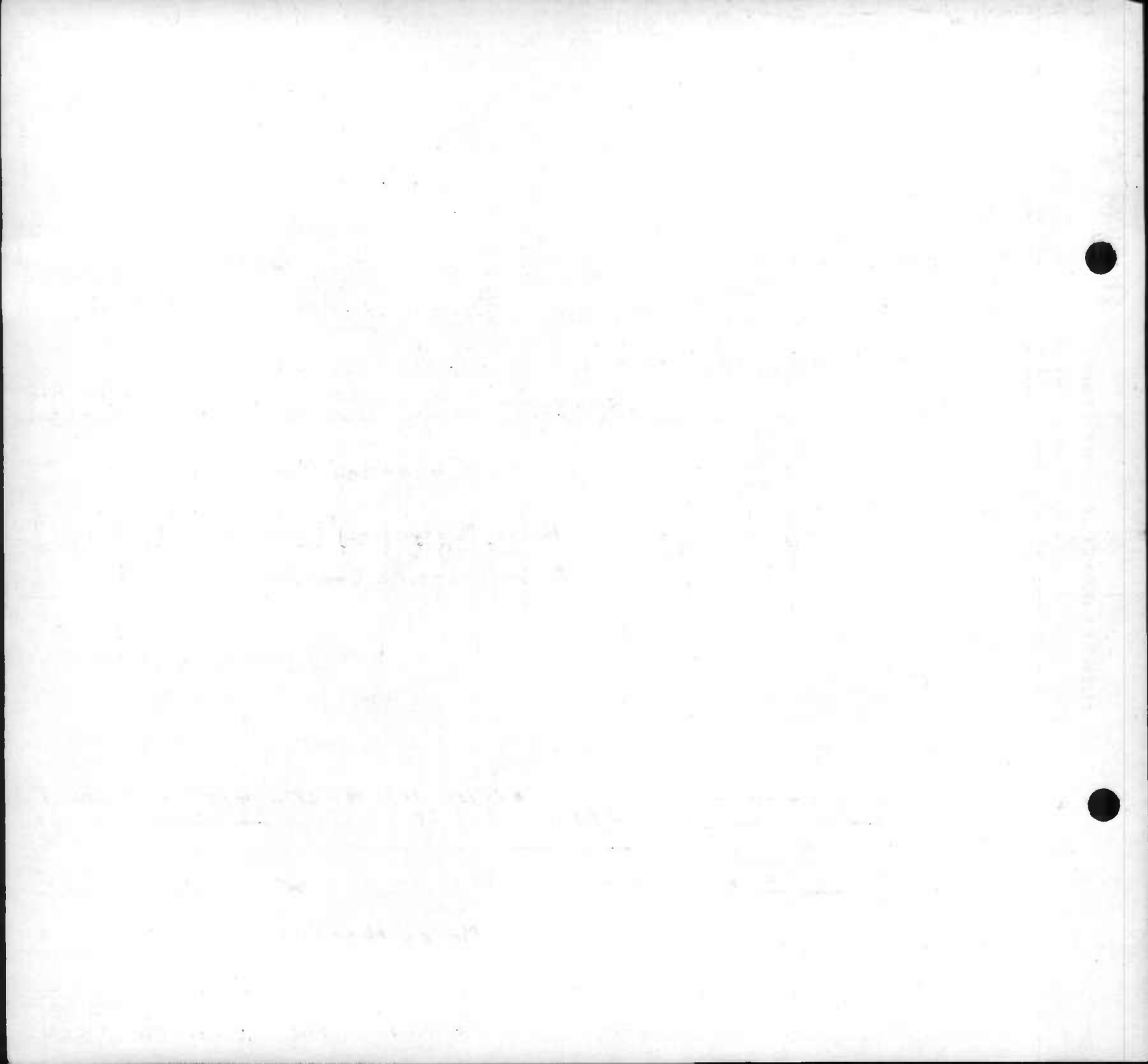
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Goris, Frank FRANK GORIS</u>		2. DATE AND HOUR OF DEATH <u>April 3rd, 1968</u>   <u>8:17</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>40 Saint Agnes Hospital</u> <u>Caton &amp; Wilkens Aves. 21229</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard 63-00</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Wayside Motel Washington Blvd. Jessup, Md.</u>	
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/93</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>shipping industry</u>		11. BIRTHPLACE (State or foreign country) <u>Antwerp, Belgium</u>	
13. FATHER'S NAME <u>Joseph Goris</u>		14. MOTHER'S MAIDEN NAME <u>Laurie</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Goris</u> ADDRESS <u>Rt 1 Wash Blvd Jessup, Md</u>	
18. <u>4/10/9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery occlusion</u> (B) <u>Atherosclerosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>64</u> to <u>4/3</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>3/23</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Norm J Weaver</u>				23B. DATE SIGNED <u>4-5-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Weaver</u>		23D. ADDRESS <u>DEGREE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairman</u>		25C. FUNERAL DIRECTOR <u>DeWitt Caraschian</u>			
25D. ADDRESS <u>Laurel Md</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-536 68-3806				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3806	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SR. M. MICHELE JINDRA</u>				2. DATE AND HOUR OF DEATH <u>APRIL 3, 1968</u>   <u>4:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 MERCY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3500 FOSTER AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8, 1894</u>	9. AGE (In years lost birthday) <u>374</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATTHIAS JINDRA</u>				14. MOTHER'S MAIDEN NAME <u>PETRONILLA BORES</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-54-3319-T</u>		17. INFORMANT <u>SACRED HEART CONVENT RECORDS</u>			
18. <u>710.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBRAL HEMORRHAGE</u> (B) <u>ACUTE MYOCARDIAL INFARCTION</u> (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR D.</u>		ADDRESS <u>3500 FOSTER AVE BALT. MD. 21224</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u> <u>24 HRS</u> <u>YEARS</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>4/3/68 1:30 PM</u> 19 <u>68</u> to <u>4/3 4:10 PM</u> 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>4/3</u> 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Jeanne S. Kraus, M.D.</u>				23B. DATE SIGNED <u>April 3, 1968</u>			
23C. PHYSICIAN'S NAME (Type) <u>Jeanne S. Kraus, M.D.</u>				23D. ADDRESS <u>MERCY HOSPITAL INC.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>APRIL 6, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>SISTERS CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>VILLAMARIA GLEN ARM MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>		25D. ADDRESS <u>8175 SCARLETT DR. TOWSON, MD. 21204</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

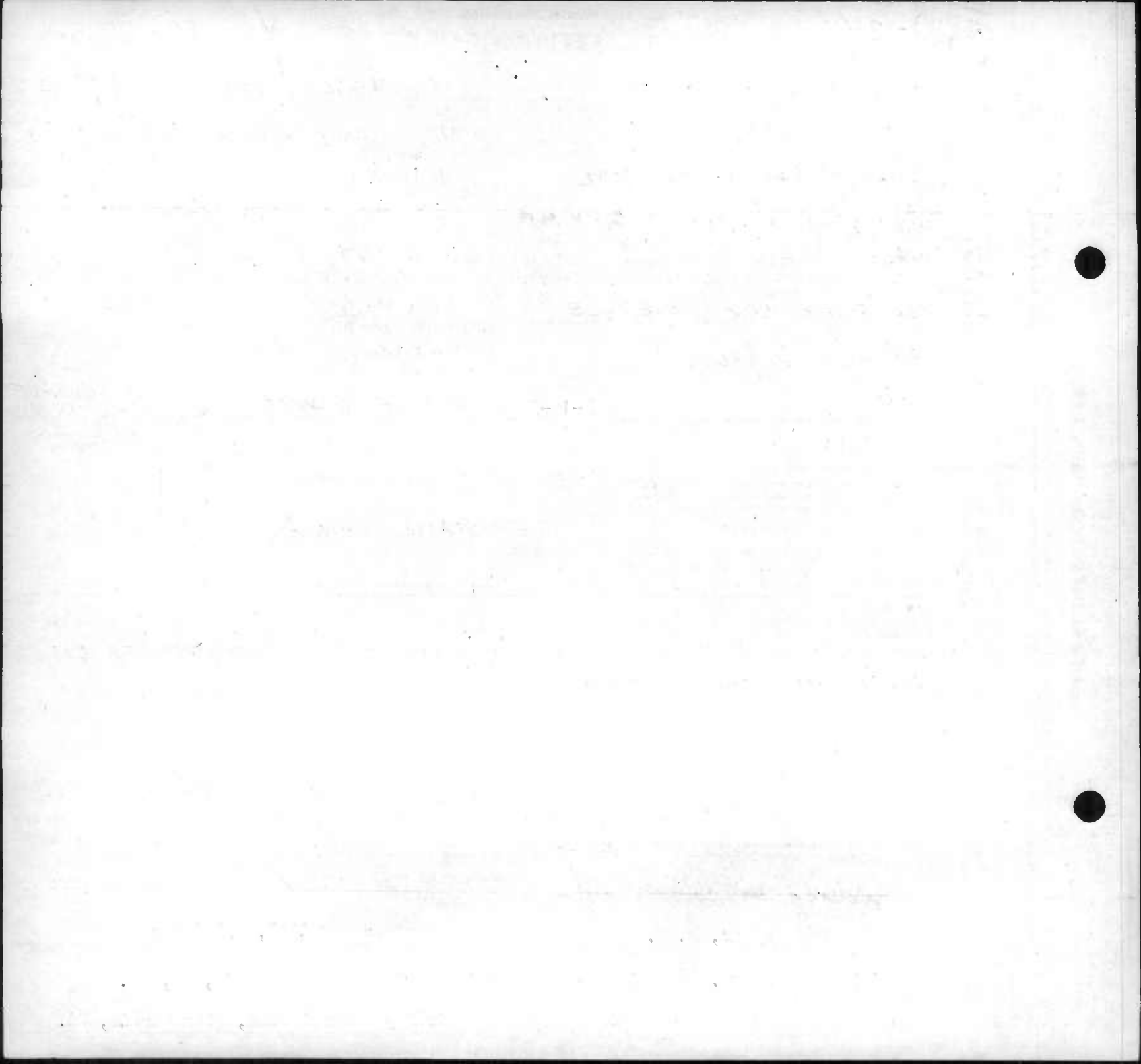
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-3807
S-530 68-3807 CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>RALPH SMITH</b>			2. DATE AND HOUR OF DEATH <b>4 APRIL 1968 12 40 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTIMORE CITY HOSPITALS</b> ADDRESS OR LOCATION <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
5. SEX <b>MALE</b>			6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>
13. FATHER'S NAME <b>JAMES Smith</b>			14. MOTHER'S MAIDEN NAME <b>ELLEN (UNK.)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-18-1013</b>		17. INFORMANT <b>RECORDS: Baltimore City Hospitals</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>491X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchopneumonia, necrotizing abscess formation.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>27 MARCH, 1968</b> to <b>4 APRIL, 1968</b> , that (I) (we) last saw the deceased alive on <b>4 APRIL, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Daniel D. Foote, M.D.</b>			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4 APRIL, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>DANIEL D. FOOTE, M.D.</b>			23D. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5 Apr. 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>	
24D. LOCATION <b>Glen Burnie, AA, Md.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Farkner</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		24H. NAME OF REGISTRAR <b>Robert E. Farkner</b>		24I. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>	

1914-15

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

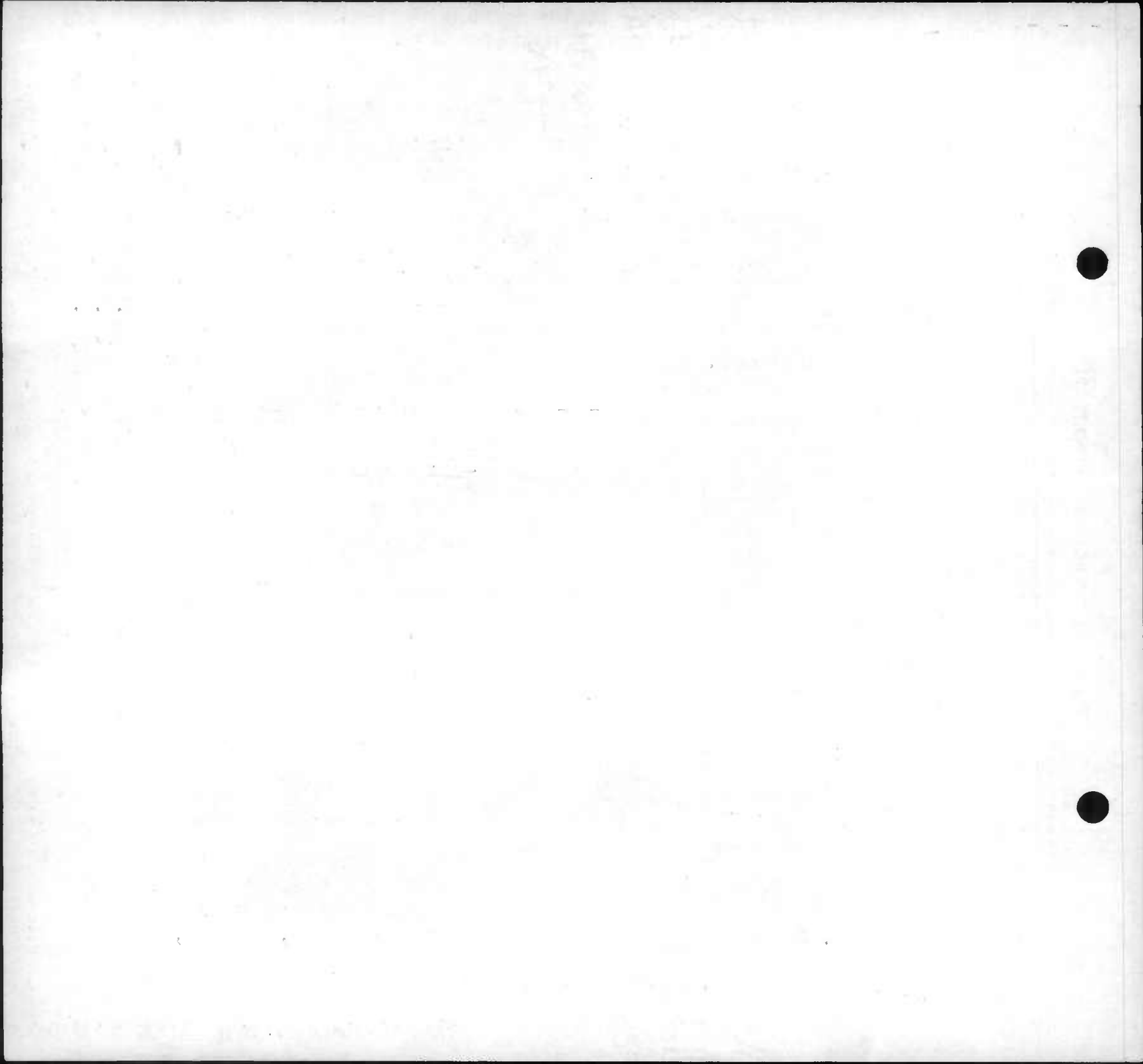
D-241		68- 3808		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68- 3808	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>RALPH Di SALVO</b>		2. DATE AND HOUR OF DEATH <b>APRIL 4, 1968 6:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL COUNTY 32-00</b>		C. CITY OR TOWN <b>PASADENA</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>JAMES L. KERNAN HOSPITAL</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALT. MD. 21207 WINDSOR MILL &amp; FOREST PARK AVE</b>		E. STREET AND NUMBER <b>102 SANDY BEACH DRIVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 4, 1907</b>		9. AGE (In years last birthday) <b>61</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOCK SUPERVISOR</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>STEVEDORE</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BERNARD Di SALVO</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN - APRILE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>563-16-5886</b>		17. INFORMANT <b>VALERIE GIANETTI</b> ADDRESS <b>8 LAKEVIEW AVE N. LINTHICUM MD</b>			
18. <b>1968 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>RESPIRATORY FAILURE</b> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>199.2 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>19A. DATE OF OPERATION</b> <b>FEB 16, 1968</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>PELVIC LESION</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY FAILURE</b> (B) <b>METASTATIC CANCER</b> DUE TO, OR AS A CONSEQUENCE OF: (C)					
19A. DATE OF OPERATION <b>FEB 16, 1968</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PELVIC LESION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb 13 1968</b> to <b>April 4 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 4 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edward M. Tapper MD</b> DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 4, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward Tapper, M. D.</b> DEGREE						23D. ADDRESS <b>Kernans Hospital, Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6 Apr. 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Tappan</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Kirkley Funeral Home, Glen Burnie, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-420		BALTIMORE CITY HEALTH DEPARTMENT		68- 3809	
68- 3809		CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES GILLES</b>		2. DATE AND HOUR OF DEATH <b>4/8/68 11 10 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31/ Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1306 North Mount Street 21217</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/80</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles H. Gilles</b>		14. MOTHER'S MAIDEN NAME <b>Tarter</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-44-3769</b>		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Plumal Effusion</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>493X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/1/68</b> 19 <b>68</b> to <b>4/8</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/8</b> 19 <b>68</b> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Jaffe</b>		23B. DATE SIGNED <b>4/8/68</b>		23C. PHYSICIAN'S NAME (Type) <b>M. Jaffe</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/13/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Zion Cem Baltimore, Co</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>	
25C. FUNERAL DIRECTOR <b>MARGARETHA R. BROWN</b>		25D. ADDRESS <b>3106 W. Brook Ave</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3810 CERTIFICATE OF DEATH

REG. NO. 68- 3810

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ASA STALNAKER

2. DATE AND HOUR OF DEATH

4-5-68 3:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS

E. STREET AND NUMBER

MD BALTO 11-02 YES ☒ NO ☐  
808 St Paul St

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐

Not While At Work ☐

22. I certify that (this hospital) attended the deceased from 7 PM April 4 1968 to April 5 1968, that (I) (we) last saw the deceased alive on 3:05 AM April 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

53

Page 11

1875

1875

1875

## CERTIFICATE OF DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Helen M. Guy</u>		2. DATE AND HOUR OF DEATH <u>4/8/68</u> <u>15</u> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>6-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3/ Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		B. DATE OF BIRTH <u>11-4-1899</u> 9. AGE (In years last birthday) <u>68</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME <u>JOHN STOCK</u>		14. MOTHER'S MAIDEN NAME <u>Helen</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. <u>4369 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>CUA</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>331Y II</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> 19 <u>68</u> to <u>4/8</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4/8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. S. Urbanelli</u>		23B. DATE SIGNED <u>4/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>J. S. Urbanelli</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-11-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 20 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
25C. FUNERAL DIRECTOR <u>Spitely Miller - 2334 Jefferson St.</u>		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

expensive

about 1200

about 1200

expensive

expensive - 1200

## 68-3812 CERTIFICATE OF DEATH

REG. NO. 68-3812

T-616		68-3812		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3812	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Charles Travers			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 4/9/1968 9.15 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 3/ Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 21224 4940 Eastern Avenue, Baltimore City Hospitals			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1893	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEVER EMPLOYED			10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Travers				14. MOTHER'S MAIDEN NAME MARY TRAVERS <del>Katherine</del>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -			16. SOCIAL SECURITY NO. 214-22-2460	17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Pulmonary Disease (B) Chronic Bronchitis + Emphysema (C) Atherosclerotic Heart Disease			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-29-1966 to April 9, 1968, that (I) (we) last saw the deceased alive on March 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Oais S. Al-Awqati M.D., Ch.B.						23B. DATE SIGNED 4-9-1968	
23C. PHYSICIAN'S NAME (Type) Oais S. Al-Awqati				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-11-68		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1968				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Jefferson St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3813 CERTIFICATE OF DEATH

REG. NO. 68- 3813

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

ROBERT STALLINGS

2. DATE AND HOUR OF DEATH

3:45

4-6-68

A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md., 21213

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3512 Elmley Ave.

5. SEX

male

6. RACE

white

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8/2/98

9. AGE (In years last birthday)

69

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Longshoreman-Internal Longshorman Assn.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Stallings

14. MOTHER'S MAIDEN NAME

Anna Boyer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-05-7829

17. INFORMANT

ADDRESS

Catherine Bagdon Stallings, wife, above

18.

162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer of the Brain, Metastatic

(B) Cancer of the Lung, Primary

DUE TO, OR AS A CONSEQUENCE OF:

(C).....

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

?

?

MEDICAL CERTIFICATION

162.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At Work ☐

Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-23-1968 to 4-6-1968, that (I) (we) lost saw the deceased alive on 4-6-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Beatrice A. Denfield, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-6-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/9/68

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPT.

APR 10 1968

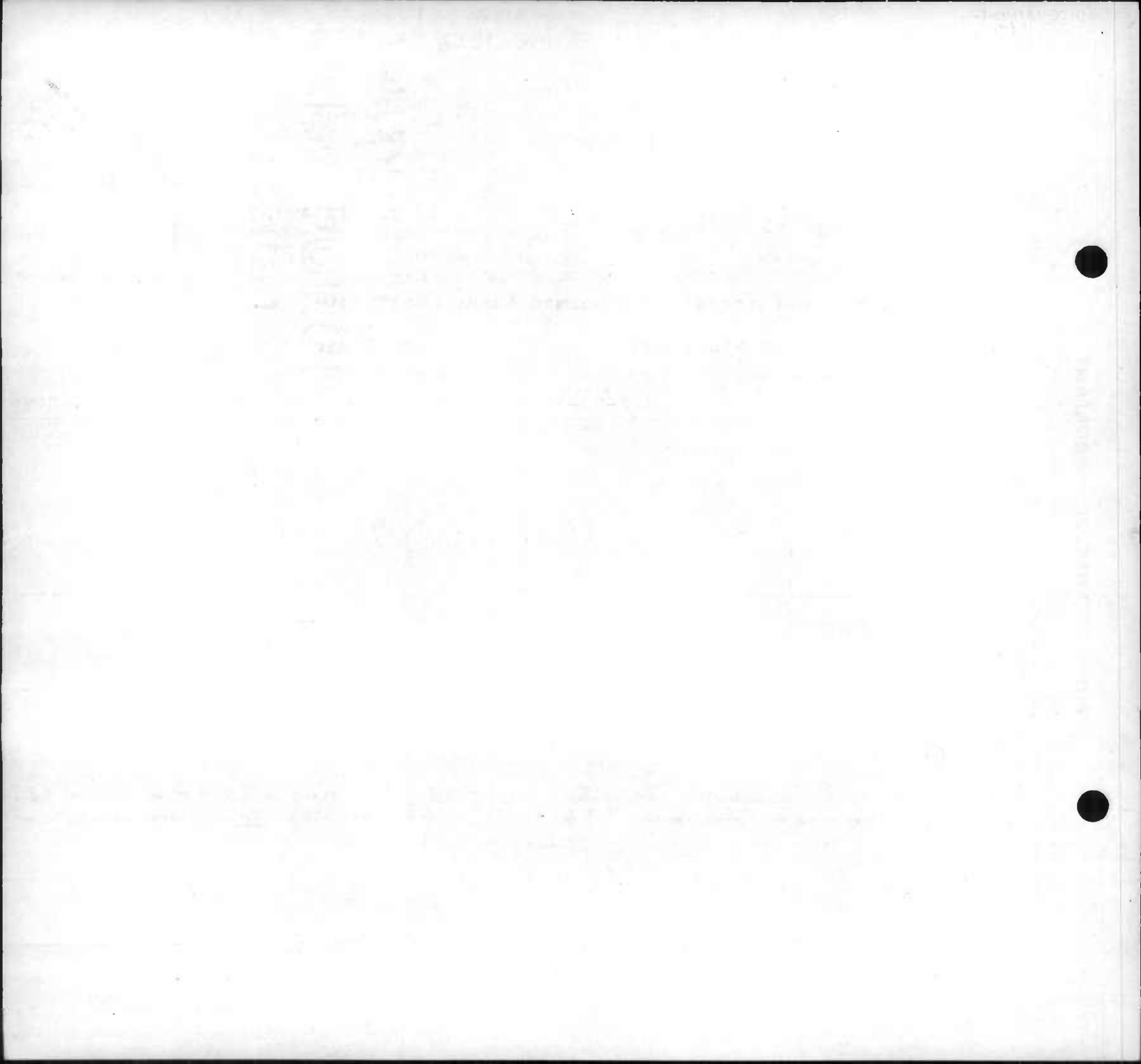
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

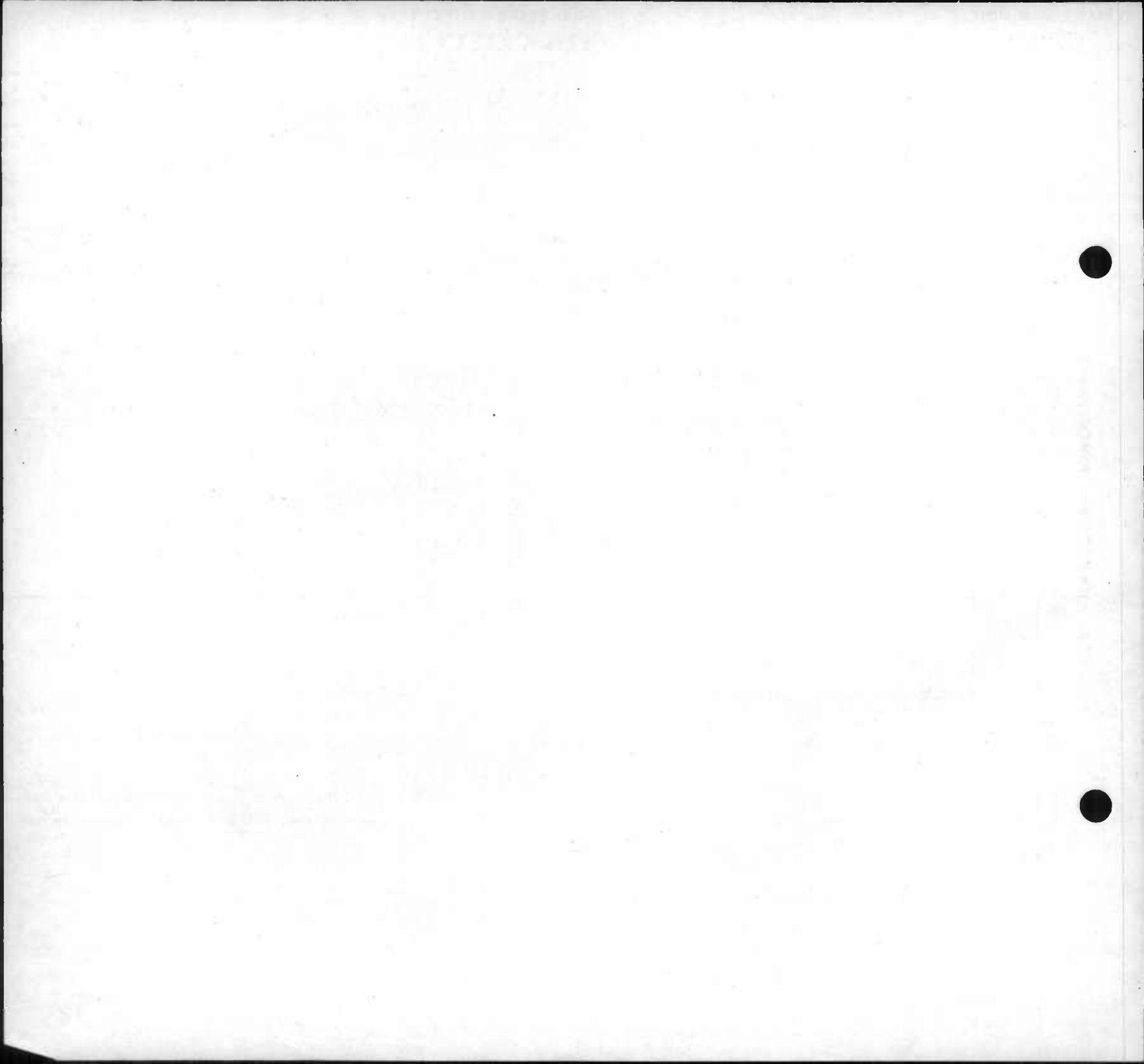
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

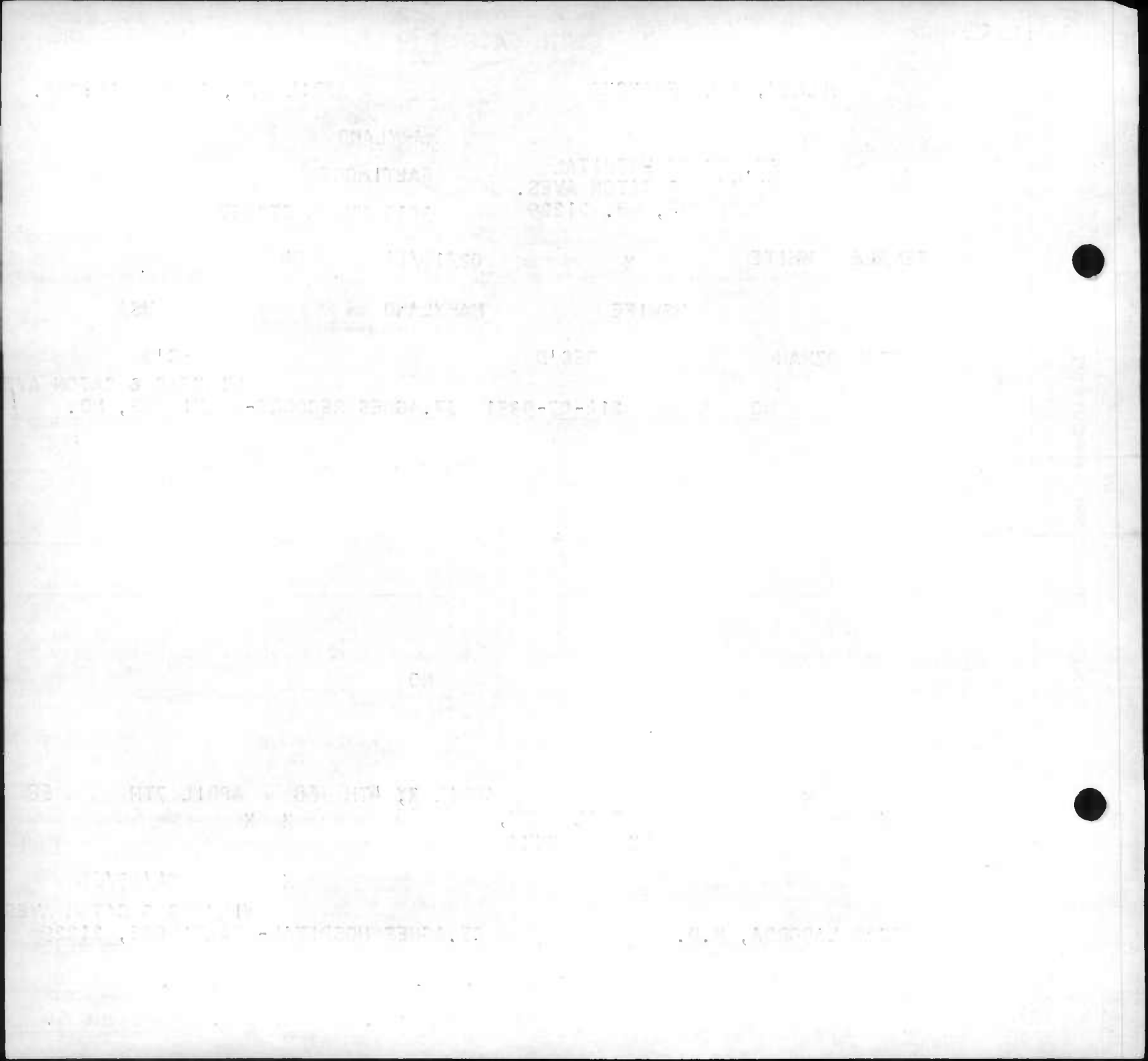
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3814	
BIRTH NO. 68-3814					
1. NAME OF DECEASED (Type or Print) JADWIGA NOWAKOWSKI			2. DATE AND HOUR OF DEATH 4/2/68 9:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO. CITY		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSP			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 808 ST. PAUL ST.		
5. SEX F	6. RACE CW	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-78	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT MR. JOSEPH NOWAKOWSKI 3408 McShane Way
18. 009,21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEMORRHAGE LG. BOWEL			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hemorrhagic enterocolitis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 571.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8:40 PM 4/1/68 to 9:15 AM 4/2/68, that (I) (we) last saw the deceased alive on 4/2/68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Susan Bollinger MD				23B. DATE SIGNED 4/2/68	
23C. PHYSICIAN'S NAME (Type) M. SUSAN BOLLINGER				23D. ADDRESS MERCY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-5-68		24C. NAME OF CEMETERY or CREMATORY ST. STANIS/ANUS CEM.	
24D. LOCATION (City, town, or county) BALTIMORE MD.		24E. NAME OF REGISTRAR Robert E. Farkas		24F. FUNERAL DIRECTOR B. DABROWSKI 241 E. Balto. St.	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3815</u>
68-3815 CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		WILLEY, ELLA FRANCES		APRIL 7TH, 1968 12:05P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  40 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		A. STATE MARYLAND		
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 3017 HURON STREET				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/18/84	9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY HSWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BOZAM OZMAN		14. MOTHER'S MAIDEN NAME DEC 'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-07-9351	17. INFORMANT WILKENS & CATON AVE ST. AGNES RECORDS-BALTIMORE, MD.	
18. <u>486 X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia, RT.</u> (B) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cachexia</u>		
19. <u>493 X</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>APRIL 8X 4TH 1968</u> to <u>APRIL 7TH 19 68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>ARRIL 7TH, 19 68</u> and that in <input checked="" type="checkbox"/> (a) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>XXXX</u> view the body after death.				
23A. SIGNATURE <u>Oscar Laborda</u>			23B. DATE SIGNED 04/07/68	
23C. PHYSICIAN'S NAME (Type) OSCAR LABORDA, M.D.			23D. ADDRESS WILKENS & CATON AVES ST. AGNES HOSPITAL- BALTIMORE, 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/10/68	24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pk.	24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR <u>Robert E. Falsky</u>	25C. FUNERAL DIRECTOR JOHN F. DENNY, INC. 715 Light St		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3816

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3816

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charlie George Pase

Charlie G. Pase

2. DATE AND HOUR OF DEATH

April 5, 1968

9:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co

53-00

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

7009 Sollers Point Rd.

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/10/01

9. AGE (In years last birthday)

67

10. Under 1 Yr.

Months

Days

11. Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Welder

10B. KIND OF BUSINESS OR INDUSTRY

Eastern Stainless Steel

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

George Pase

14. MOTHER'S MAIDEN NAME

Margaret Mullanex

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)

Yes 1919-1923 Navy

16. SOCIAL SECURITY NO.

232-09-7290

17. INFORMANT

(Wife)

Dundalk, Md. 21222

Mrs. Gertrude Pase, 7009 Sollers Pt. Rd.

18. 5-27-2 II

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Chronic Obstructive Airway Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 5 1968 to April 5 1968, that (I) (we) last saw the deceased alive on April 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard H. Bard, MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

April 5, 1968

23C. PHYSICIAN'S NAME (Type)

Richard H. Bard, MD

23D. ADDRESS

University of Maryland Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/9/68

24C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Dorsey, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

John J. Duda, 7922 Wise Ave. Dundalk, Md.

George Rose  
 West Virginia  
 1/10/01  
 1000 Soller Point Rd  
 Baltimore  
 Maryland

Chas. Robertson Acting Director

222-07-121

Richard H. Bond, M.D.  
 University of Maryland Hospital

April 2, 1901

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3817</b>
<b>B-420</b>		<b>68-3817</b>		<b>CERTIFICATE OF DEATH</b>
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILFRED BLACK</b>		
		2. DATE AND HOUR OF DEATH <b>4/6/68 1:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND GENERAL</b>		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMIT? <b>YES</b> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1701 Brookview Rd. Dundalk, Md. 21222</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/05</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Taubmans</b>		11. BIRTHPLACE (State or foreign country) <b>CAMBRICK, PA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>William BLACK</b>		14. MOTHER'S MAIDEN NAME <b>Orfie EDWARDS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>171-07-0052</b>		17. INFORMANT (Wife) <b>Mrs. Sara E. Black</b>
		ADDRESS <b>Dundalk, Md.</b>		Rd. <b>1701 Brookview</b>
18. <b>410.9 + 2150.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>				<b>years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II Disturbances mellitus</b>				<b>years.</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>No</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>No</b>
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/23</b> 19 <b>68</b> to <b>4/6</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/5</b> 19 <b>68</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.				
23A. SIGNATURE <b>C. E. DeFelicis</b>				23B. DATE SIGNED <b>4/6/68</b>
23C. PHYSICIAN'S NAME (Type) <b>C-E. DeFelicis</b>		23D. ADDRESS <b>MARYLAND GENERAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/9/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>
24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>John E. Tarkenton</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-430		68-3818		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3818	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>LILLIAN F. Holt</b>			
2. DATE AND HOUR OF DEATH <b>4/6/68 11:20 AM</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore Co.</b> <b>53-00</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>				C. CITY OR TOWN <b>Sparrows Point</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>1332 BEACHWOOD Rd 21219</b>							
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/4/21</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Isaac Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Welsh</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-22-2785</b>		17. INFORMANT RECORDS: Baltimore City Hospitals <b>4940 Eastern Avenue, Baltimore, Md. 21224</b>	
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>330X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).				CAUSE OF DEATH <b>ANTERIOR COMMUNICATING ARTERY ANEURISM WITH RUPTURE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERAL HOURS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>4/6 1968</b> to <b>4/6 1968</b> , that (we) last saw the deceased alive on <b>4/6 1968</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Marvin Mengel M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/6/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARVIN MENGEL M.D.</b>				23D. ADDRESS <b>4940 Eastern Ave., Balto., Md. 21224</b> <b>BALTIMORE CITY HOSPITALS</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>R. E. F. Jones</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			

AMERICAN (COMMUNIST) PARTY  
AMERICAN (COMMUNIST) PARTY

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3819

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PEDRO GAMINDE JR.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 6, 1968 9:00 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 9:00 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 16, 1921</b>		10. AGE (In years lost birth day) <b>46</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Pedro Gaminde Sr.</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
15. MOTHER'S MAIDEN NAME <b>Felisa Uriarte</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>	
17. SOCIAL SECURITY NO. <b>234-22-2904</b>		18. INFORMANT (Wife) ADDRESS <b>Balto. Md. Mrs. Virginia Gaminde, 1620 Joplin St.</b>	
19. <b>E 812.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Dundalk and Hartwait Streets</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4-2-68 11:45 P.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver in auto-auto collision</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

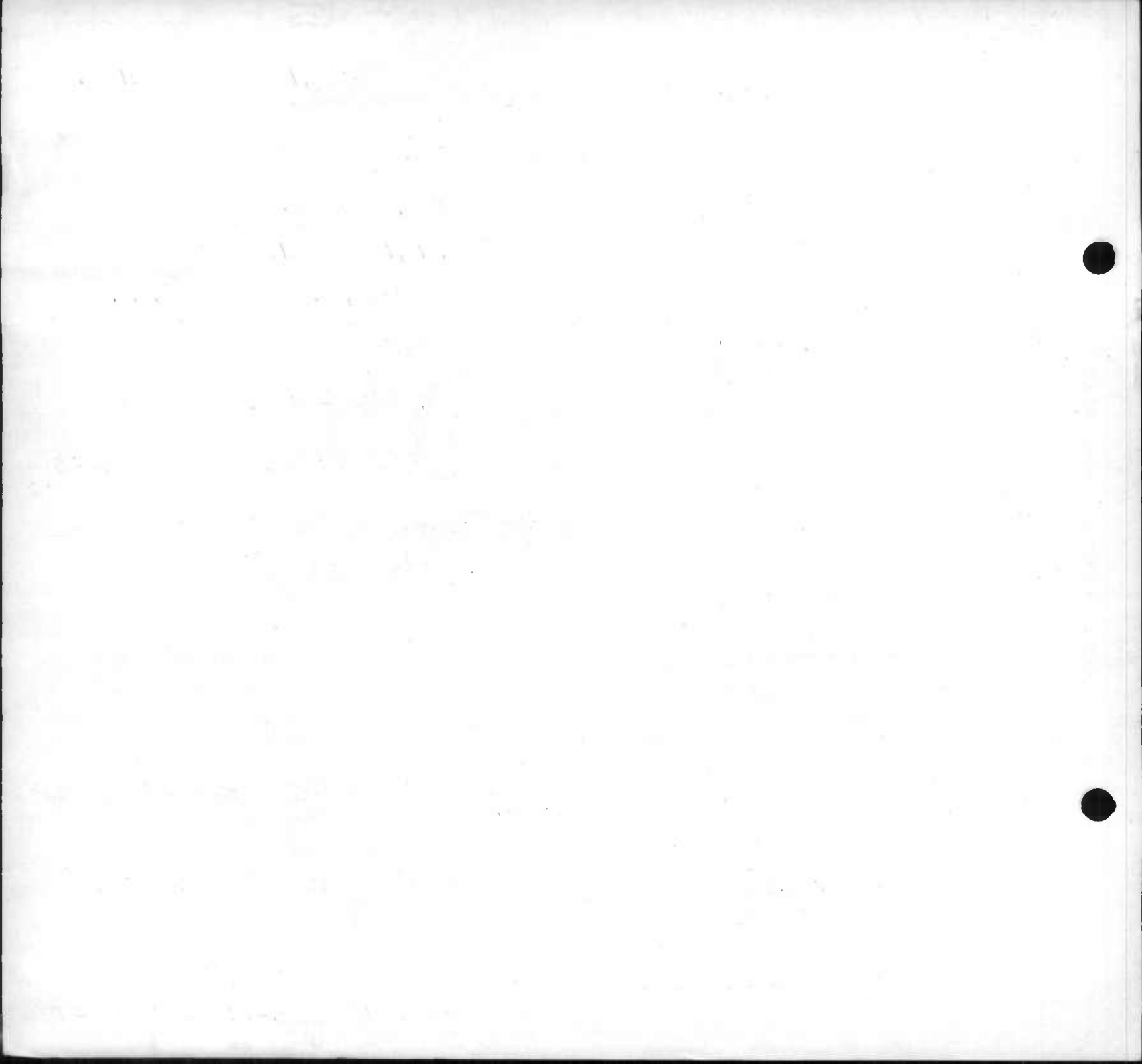
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3820
BIRTH NO. 68- 3820		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>LEWIS, WILLIAM C.</b>		2. DATE AND HOUR OF DEATH <b>April 8, 1968 10:10 a. m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore Co.</b> C. CITY OR TOWN <b>Middle River</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>6 Right Elevator Dr. #20</b>				
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 25, 1919</b>	9. AGE (In years lost birthday) <b>48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grounds Keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>
13. FATHER'S NAME <b>William Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rose</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>235 18 2812</b>		17. INFORMANT <b>Thelma Marie Lewis</b> ADDRESS <b>Same</b>
18. <b>173.8 I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive Pulmonary embolism 10 min.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Infected amputation stump 10 days</b>		
		(C) <b>Sarcoma of R. lower extremity 2 years</b>		
<b>199.1 II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>R. hip disarticulation</b>		
19A. DATE OF OPERATION <b>March 25, 1968</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Sarcoma of leg</b>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>March 23 1968</b> to <b>April 8 1968</b> , that (I) (we) last saw the deceased alive on <b>April 8 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE <b>S. K. Chung</b> MB, BS. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 8, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>S. K. CHUNG</b> MB, BS. DEGREE		23D. ADDRESS <b>Sinai Hospital of Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>4/9/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Richlands Funeral Home</b>		24D. LOCATION (City, town, or county) (State) <b>Richlands, Virginia</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>R. E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Prusdzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>

*James M. Smith*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

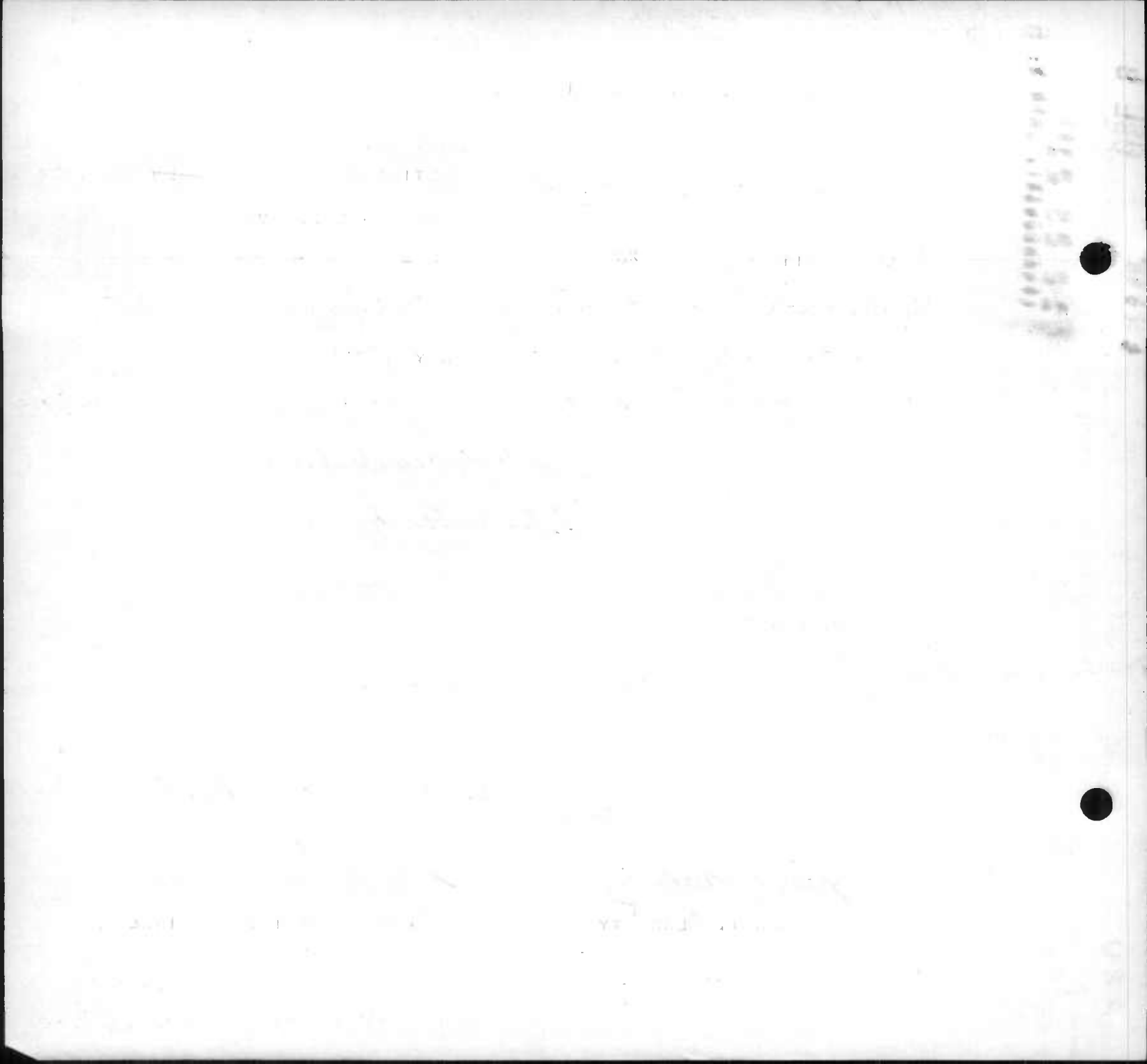
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>68-3821</u>	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Nellie C. Calvert</u>		2. DATE AND HOUR OF DEATH <u>April 3, 1968</u> <u>4:15 A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Gould Convalescent Home</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>710 E. 36th Street</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1886</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Theater</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Hook</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Lannon</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary E. Walter - 710 E. 36th Street</u>		ADDRESS	
18. <u>404 X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Cardio-</u> (C) <u>Renal Vascular Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>10 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>442 X</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <u>April 1 1968</u> to <u>April 3 1968</u> that (I) (we) last saw the deceased alive on <u>April 1 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles F. O'Donnell</u>				23B. DATE SIGNED <u>4/4/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>				23D. ADDRESS <u>John C. Miller Inc. - 6415 Belair Road - 21206</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>John C. Miller Inc. - 6415 Belair Road - 21206</u>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

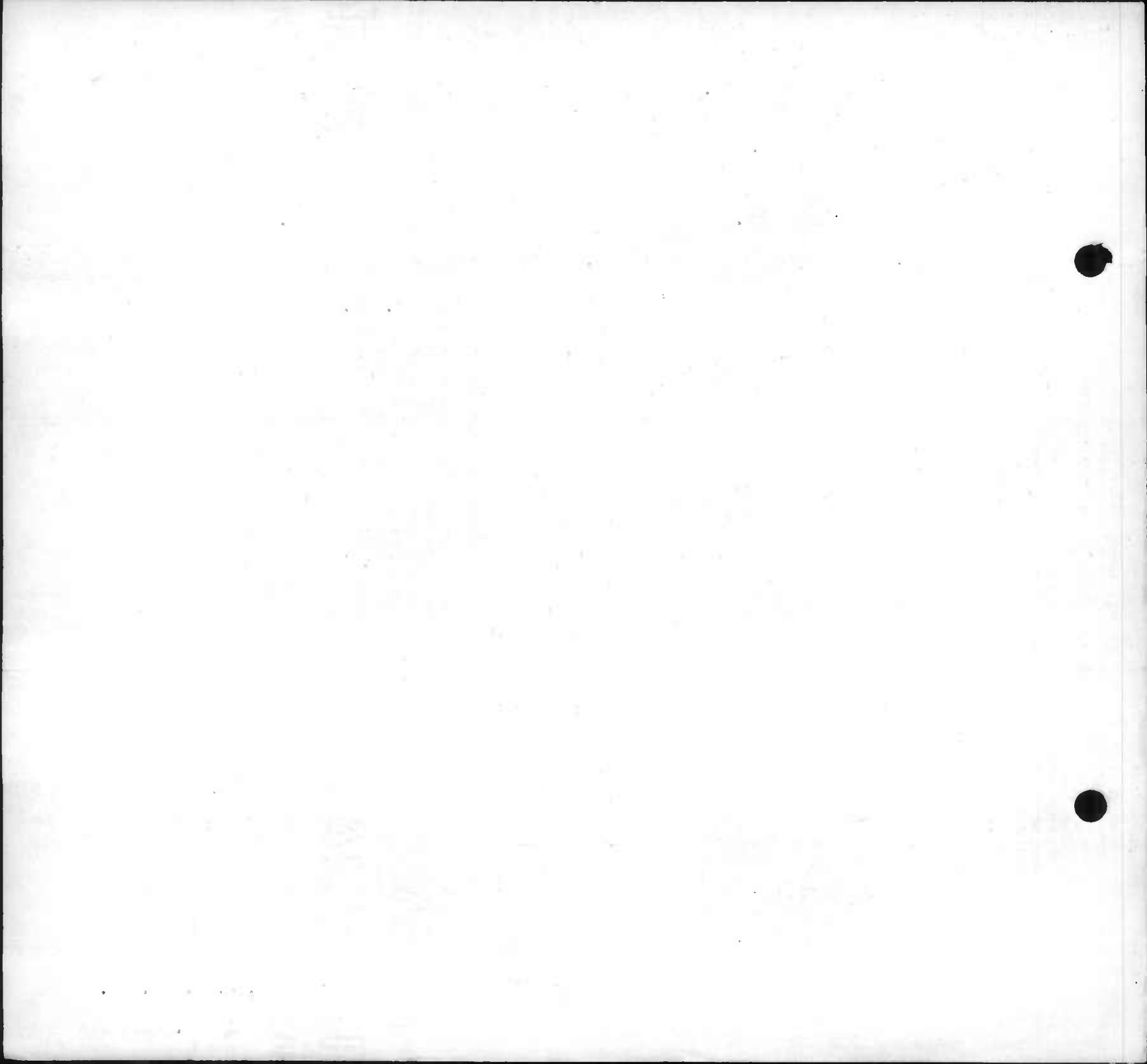
BALTIMORE CITY HEALTH DEPARTMENT														
L-532 68-3822 CERTIFICATE OF DEATH					REG. NO. 68-3822									
BIRTH NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					JOHN W. LEWANDOWSKI					4/6/68 2 20 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					53-00				
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? <del>NO</del> NO <input checked="" type="checkbox"/> NO				
5. SEX MALE					6. RACE WHITE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer					10B. KIND OF BUSINESS OR INDUSTRY Furniture Company					8. DATE OF BIRTH 3-8-12				
13. FATHER'S NAME Stanislaus Lewandowski					14. MOTHER'S MAIDEN NAME MARY Sokolowski					9. AGE (In years last birthday) 56				
15. Was Deceased Ever in U. S. Armed Forces? (Yes (no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 213-10-7206					11. BIRTHPLACE (State or foreign country) Maryland				
										12. CITIZEN OF WHAT COUNTRY? USA				
										17. INFORMANT John S. Lewandowski, 7906 Roseland Ave				
										ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4/10/68 I Acute myocardial infarction					CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD									
					(B) DUE TO, OR AS A CONSEQUENCE OF:									
					(C) DUE TO, OR AS A CONSEQUENCE OF:									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4/20/68 II														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
					While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/>									
22. I certify that (1) (this hospital) attended the deceased from April 5 1968 to April 6 1968, that (1) (we) last saw the deceased alive on April 6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.														
23A. SIGNATURE John T. Flaherty					23B. DATE SIGNED 4/6/68									
23C. PHYSICIAN'S NAME (Type) JOHN T. FLAHERTY					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-10-68					24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery				
										24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. APR 10 1968					25B. NAME OF REGISTRAR Robert E. Fairbank					25C. FUNERAL DIRECTOR Philip E. Cruch 1211 Chesapeake Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 3823</u>
BIRTH NO. <u>68- 3823</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Myrtle V. Bevans</u>		2. DATE AND HOUR OF DEATH <u>April 5, 1968</u> <u>7:30 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1431 William St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1431 William St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 17 1901</u>	9. AGE (In years lost birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Henry Bush</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		
18. ADDRESS <u>Same</u>		19. CAUSE OF DEATH		
18. <u>410.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>  (B) <u>Arteriosclerosis &amp; Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery Disease</u>  (C) _____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>7/4/49</u> 19 <u>68</u> to <u>4/5/</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4/5/68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>H. P. Friedman M.D.</u> DEGREE				23B. DATE SIGNED <u>4/8/68</u>
23C. PHYSICIAN'S NAME (Type) <u>H. P. Friedman M.D.</u> DEGREE				23D. ADDRESS <u>1319 LIGAT ST.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4 9 68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>
24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>Mc Cully</u>		
25D. ADDRESS <u>130 E. Fort Ave</u>				



I-251

68-3824

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3824

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jams, Mrs Louise P.

2. DATE AND HOUR OF DEATH

April 4, 1968

5 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

91

Keswick

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

700 W. 40th St.

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

11-23-79

9. AGE (In years  
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Whitehouse

14. MOTHER'S MAIDEN NAME

Louisa Snyder

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

216-10-2225

17. INFORMANT

Helen E. Leau, P. N. - Home Records

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Thrombosis

8 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis

3 1/4 yrs

(C)

Cervical Cord Compression due to Osteoarthritis

11 yrs

MEDICAL CERTIFICATION

332X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MAR 14 1968 to April 4 1968,  
that (I) (we) last saw the deceased alive on April 4 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

Aubrey D. Richardson, M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☒Staff  
Phys. ☐

23B. DATE SIGNED

4 April 1968

23D. ADDRESS

700 W. 40th Street 21211

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

4/6/1968

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 10 1968

25B. NAME OF REGISTRAR

Aubrey D. Richardson

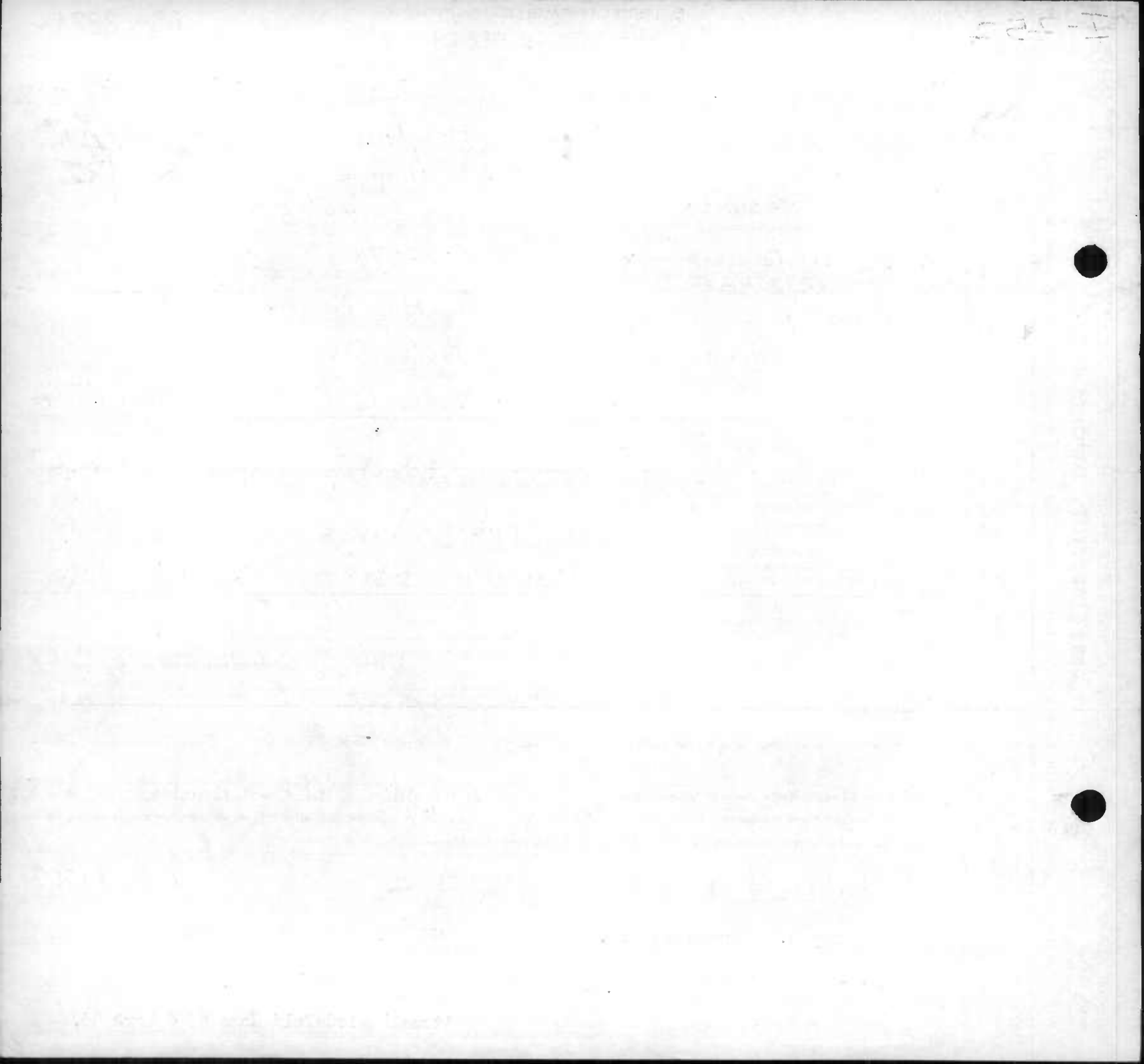
25C. FUNERAL DIRECTOR

ADDRESS

Mitchell Wiedefeld Home 6500 York Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

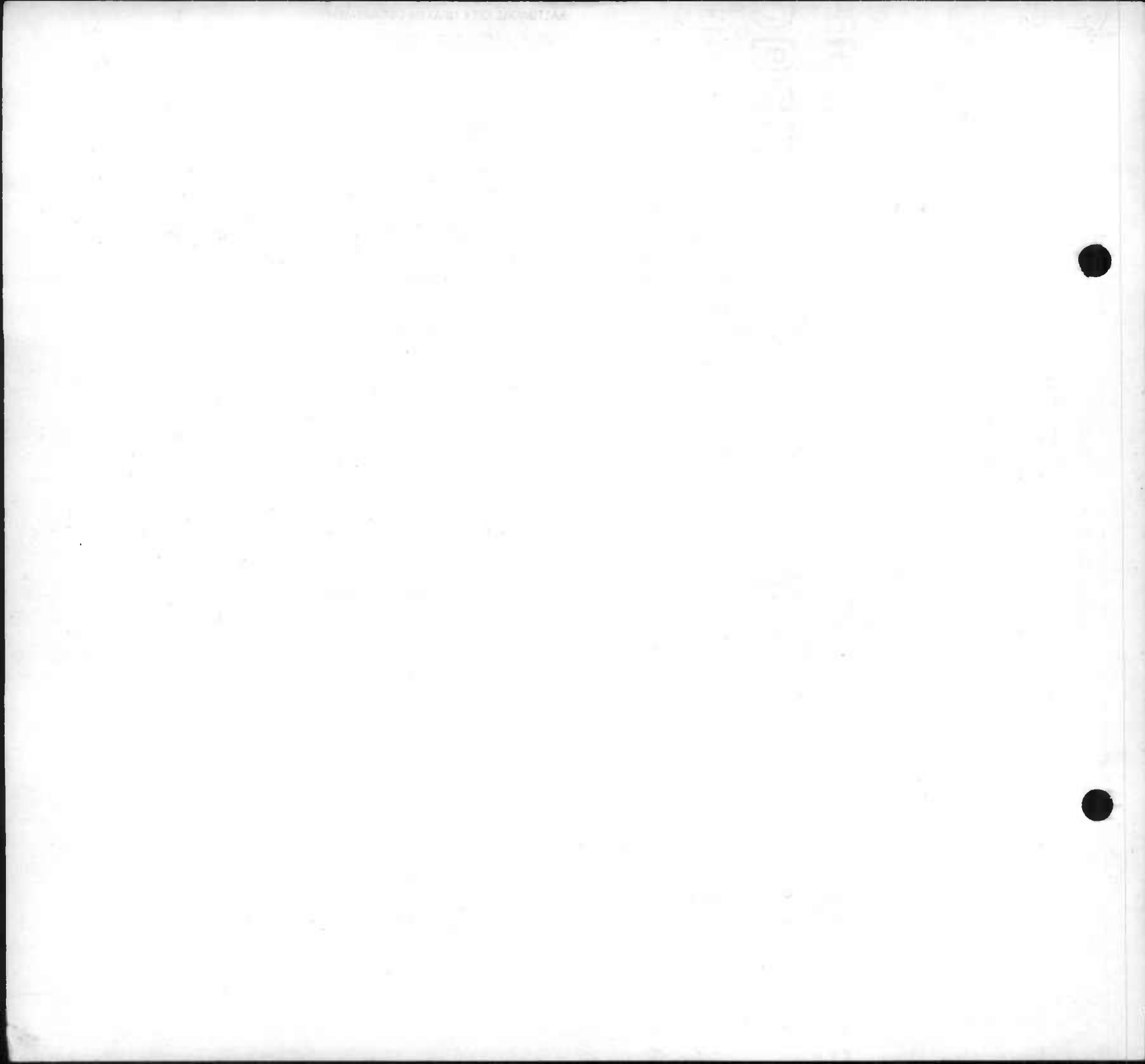


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
 68-3825  
 CERTIFICATE OF DEATH  
 REG. NO. 68-3825

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PAYTON, EDWARD EUGENE</b>		2. DATE AND HOUR OF DEATH <b>5 APR 68 12:40 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? <b>YES</b>	
5. SEX <b>M</b>		6. RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/19/28</b>		9. AGE (In years last birthday) <b>38</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN ROBINSON</b>	
14. MOTHER'S MAIDEN NAME <b>MARIE JACKSON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARIE JACKSON 911 MT. HOLLY ST</b>		ADDRESS			
18. <b>5300 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PERITONITIS</b>		<b>2 Days</b>	
ANTECEDENT CAUSES		(B) <b>PERFORATED PEPTIC ULCER</b>		<b>2 Days</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
19. DATE OF OPERATION <b>NONE</b>		20. AUTOPSY? (Yes or No) <b>YES</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <b>5 APR 1968</b> to <b>5 APR 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23. SIGNATURE <b>Grant R. Fairbanks, M.D.</b>		24. DATE SIGNED <b>5 APR 68</b>	
25. PHYSICIAN'S NAME (Type) <b>GRANT R. FAIRBANKS, M.D.</b>		26. ADDRESS <b>UNIVERSITY HOSP.</b>			
27. BURIAL, CREMATION, REMOVAL (Specify) <b>Burned</b>		28. DATE <b>4/10/68</b>		29. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN</b>	
30. LOCATION (City, town, or county) <b>BALTIMORE</b>		31. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		32. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
33. FUNERAL DIRECTOR <b>Marshall P. Hays</b>		ADDRESS <b>638 N GILMORE ST</b>			



68- 3826

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3826

## BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

MARCELINE

BRIGHT

## 2. DATE OF DEATH

Known ☐ Estimated ☒

Month

Day

Year

Hour

April 8, 1968

4:30 P.M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

## 3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

April 9, 1968

2:25 A.M.

## 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒ NO ☐

## 6. SEX

female

## 7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 9. DATE OF BIRTH

9-22-1897

## 10. AGE (In years lost birthday)

70

## 11. BIRTHPLACE (State or foreign country)

BALTO MD

## 12. CITIZEN OF WHAT COUNTRY?

USA

## E. STREET AND NUMBER

3007 Raynor Avenue

## 13. FATHER'S NAME

Francis C. Dorsey

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Homemaker

## 14B. KIND OF BUSINESS OR INDUSTRY

At Home

## 15. MOTHER'S MAIDEN NAME

Mary E. Johnson

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

## 17. SOCIAL SECURITY NO.

213-30-7043A

## 18. INFORMANT

## ADDRESS

Eva Bright 3007 Raynor Ave

## 19. 412.9 I

## CAUSE OF DEATH

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/9/68

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

4/13/68

## 24C. NAME of CEMETERY or CREMATORY

Mt CALVARY

## 24D. LOCATION (City, town, or county) (State)

BALTO MD 21225

## 25A. DATE REC'D BY HEALTH DEPT.

APR 10 1968

## 25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

## 25C. FUNERAL DIRECTOR

## ADDRESS

Marshall P. Lynn 638 N. Gilman St

WALSH & CO

NEW YORK

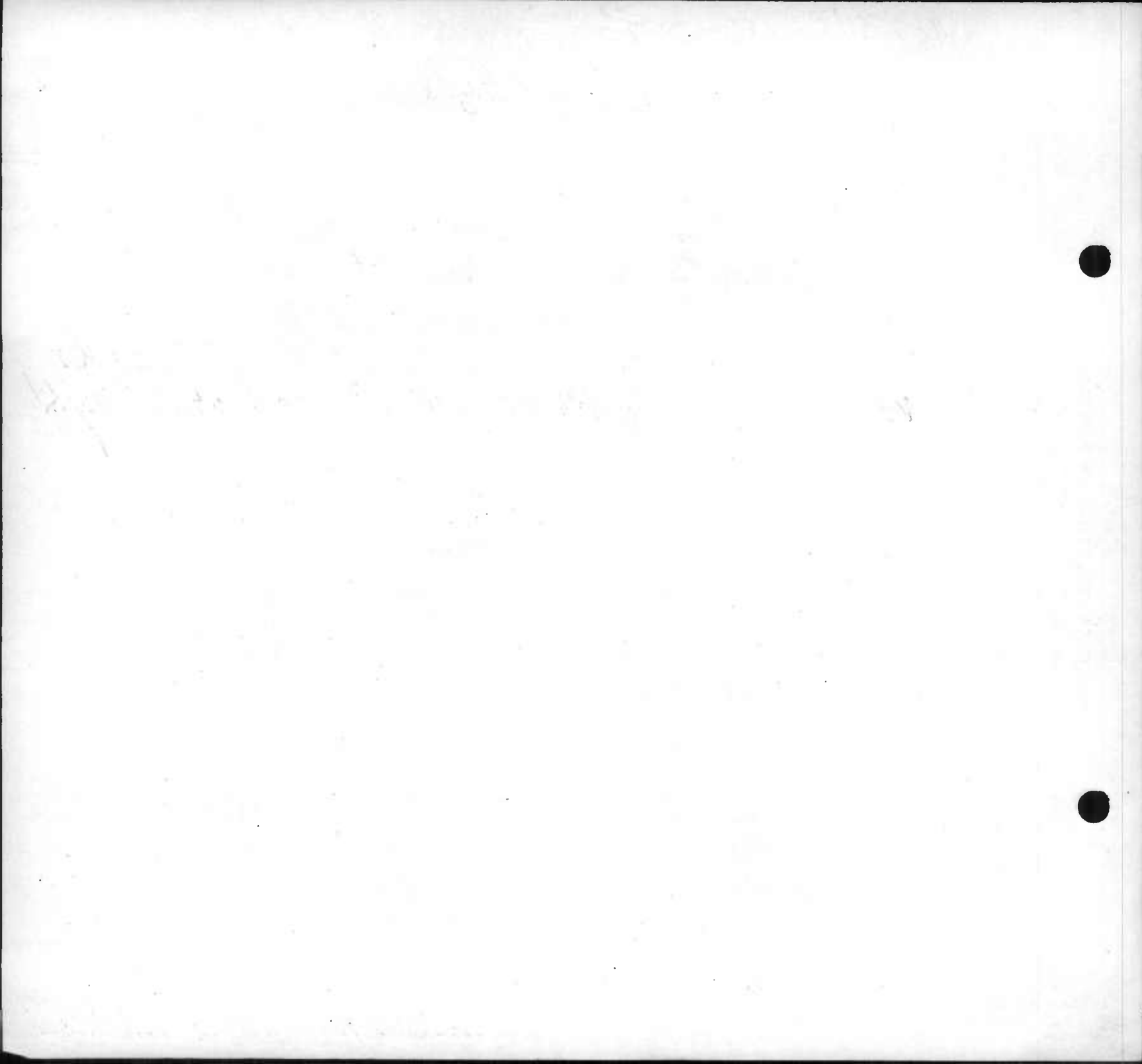
1880

W. B. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

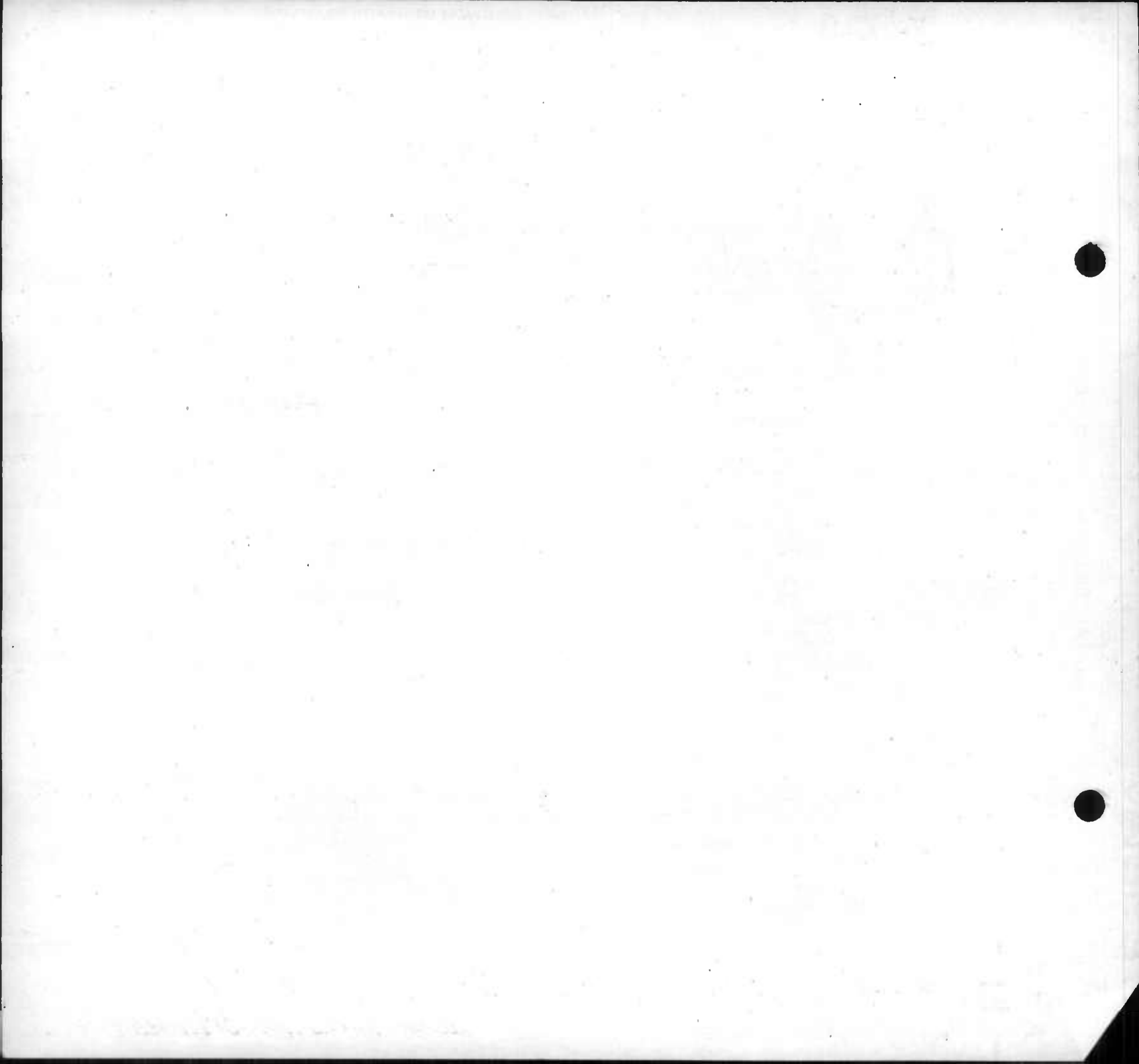
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-3827	
<div style="display: flex; justify-content: space-between;"> <span>M-234</span> <span>68-3827</span> </div>							
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED            (Type or Print) <i>McDowell, Robert Hazell</i> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <i>April 9, 1968 10:20 A.M.</i> </div> </div>							
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <i>34 Bon Secours Hospital</i> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>  </div> </div>				<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> <i>Male</i> <b>6. RACE</b> <i>negro</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <i>9-24-09</i> <b>9. AGE</b> (In years last birthday) <i>58</i> <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Farmer</i> <b>10B. KIND OF BUSINESS OR INDUSTRY</b>			
<b>11. BIRTHPLACE</b> (State or foreign country) <i>South Carolina</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U. S.</i>				<b>13. FATHER'S NAME</b> <i>Fral McDowell</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Elaine M. Fadden</i>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				<b>16. SOCIAL SECURITY NO.</b> <i>25-267357</i> <b>17. INFORMANT</b> <i>Agnes M. McDowell</i> <b>ADDRESS</b> <i>542 N. Carey St.</i>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>153.21</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <i>Adenocarcinoma of descending colon with metastases to the liver</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
<b>19. DATE OF OPERATION</b> <i>19th March 1968</i> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <i>Colostomy for colon tumor</i>				<b>20A. AUTOPSY?</b> (Yes or No) <i>Yes</i> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <i>Yes</i>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>19th March 1968</i> <b>to</b> <i>7th April 1968</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>7th April 1968</i> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <i>[Signature]</i> <b>DEGREE</b>				<b>23B. DATE SIGNED</b> <i>7th April 1968</i> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>SAI ROX PARK</i> <b>DEGREE</b>				<b>23D. ADDRESS</b> <i>Bon Secours Hospital</i>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <i>Shipped</i>		<b>24B. DATE</b> <i>4/10/68</i>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <i>St. Johns Cem.</i>		<b>24D. LOCATION</b> (City, town, or county) (State) <i>Lynchburg S.C.</i>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>APR 10 1968</i>		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. [Signature]</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Williams Funeral Home</i>		<b>ADDRESS</b> <i>319 N. Schroeder St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

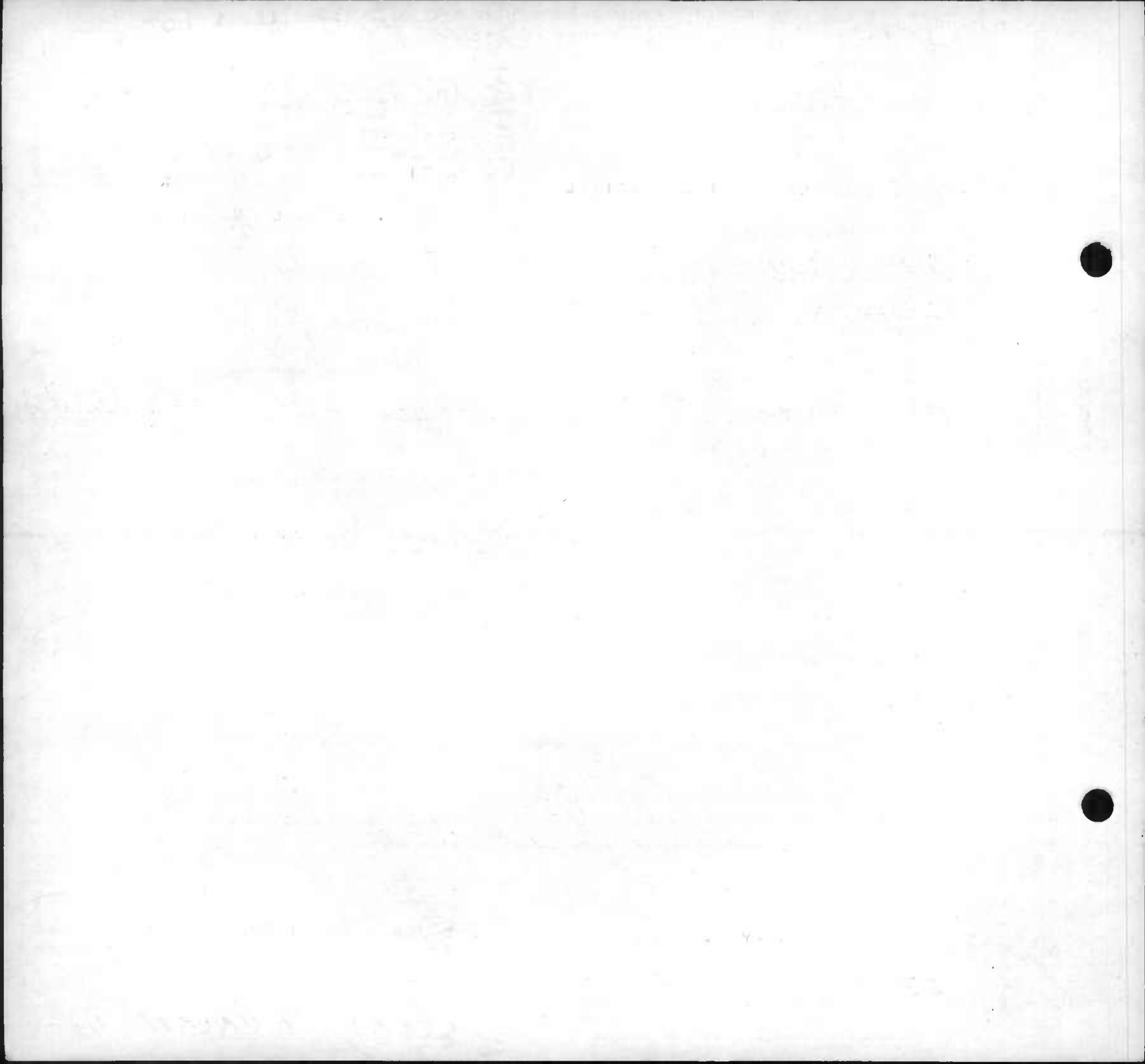
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>12188-3828</u>
J-525		68- 3828		CERTIFICATE OF DEATH
BIRTH NO. <u>525</u>		1. NAME OF DECEASED (Type or Print) <u>JOHNSON, RELTUS</u>		
2. DATE AND HOUR OF DEATH <u>4-06-68</u> <u>12:15</u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Polton Hill Nursing &amp; Convalescent Ctr.</u>		
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>761 W. Mulberry St.</u>		5. SEX <u>Male</u> 6. RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>1-22-06</u> 9. AGE (In years last birthday) <u>62</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Cleavlan Johnson</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>218-10-2563</u>		17. INFORMANT ADDRESS <u>Mrs. Dolley Tayler 793 W. Saratoga st</u>		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>1619 I</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CA 7 lung with pt. in July 1967</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>161X II</u>		(B) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> 19 <u>68</u> to <u>4/6</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>ae m...</u>		23B. DATE SIGNED <u>4/6/68</u>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>		23D. ADDRESS <u>2 E Real St Balt Md 11202</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/10/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>
24D. LOCATION (City, town, or county) <u>Balto. Md</u>		(State)		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u> ADDRESS <u>319 N. Schroeder St.</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

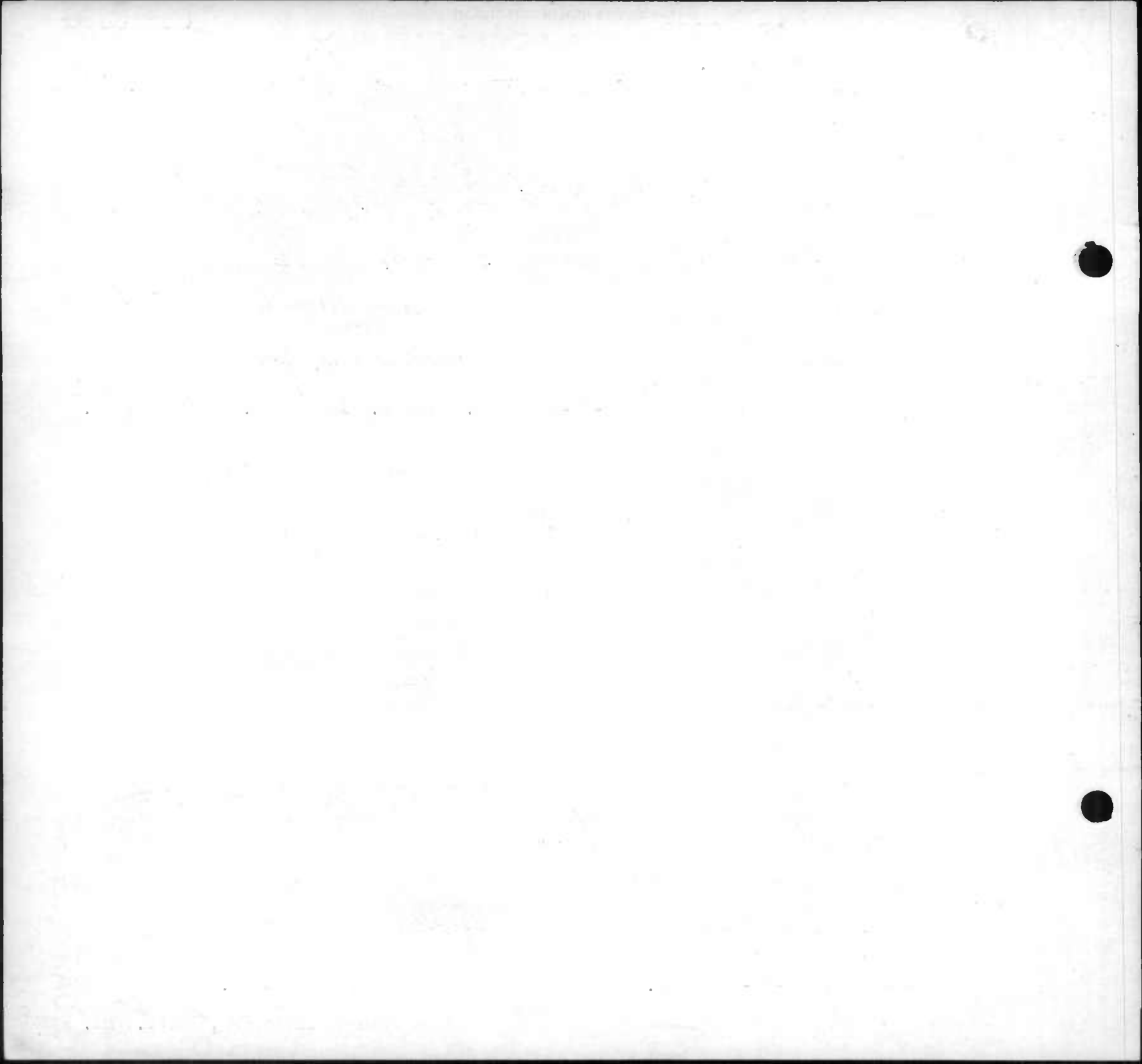
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-3829	
I-160 68-3829										CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lewis Ivory</u>					2. DATE AND HOUR OF DEATH <u>4/5/68</u> <u>9/10</u> M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1036 N. CENTRAL AVE 21202</u>						
5. SEX <u>MALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-97</u>		9. AGE (In years last birthday) <u>70</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>?</u>					14. MOTHER'S MAIDEN NAME <u>?</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI-9/24/18-3/19/19</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARGARET IVORY 1036 N. Central Ave</u>				
18. <u>4/10/68</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary artery accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Artery Myocardial Infarction,</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>											
19A. DATE OF OPERATION <u>2</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <u>3/11</u> 19 <u>68</u> to <u>4/4</u> 19 <u>68</u> , that (we) lost the deceased on <u>4/4</u> 19 <u>68</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Murray A. Katz</u>					23B. DATE SIGNED <u>4/5/68</u>					23C. PHYSICIAN'S NAME (Type) <u>MURRAY A. KATZ</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>4/10/68</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTO. NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>5501 FREDERICK AVE</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1968</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>LOCK'S FUNERAL HOME</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 3830	
CERTIFICATE OF DEATH				REG. NO. 68- 3830	
BIRTH NO. 68- 3830					
1. NAME OF DECEASED <b>Kathryn E. Miller</b> (Type or Print) <b>KATHERINE MILLER</b>			2. DATE AND HOUR OF DEATH <b>4.9.68</b> <b>1:05</b> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Md</b>			C. CITY OR TOWN <b>Balto 21207</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>7119 Rolling Bend Road 53-0</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10.26.91</b>	9. AGE (In years last birthday) <b>76</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Conrad</b>		14. MOTHER'S MAIDEN NAME <b>Catherine(Poole) Conrad</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-5287</b>		17. INFORMANT ADDRESS <b>7119 Rolling Bend Road</b> <b>Mr. Oscar H. Miller, Sr., Baltimore, Md.</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarct</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>4.20.1 II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>4.20.1 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4.5.68</b> 19 to <b>4.9.68</b> 19, that (I) (we) last saw the deceased alive on <b>4.9.68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Rafael</b> DEGREE				23B. DATE SIGNED <b>4.9.68</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. RAFAEL</b> DEGREE				23D. ADDRESS <b>Lutheran Hospital</b> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-12-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4101 Edmondson Avenue</b> <b>Witzke Funeral Directors, Balto., Md. 21229</b>	



68- 3831

BALTIMORE CITY HEALTH DEPARTMENT

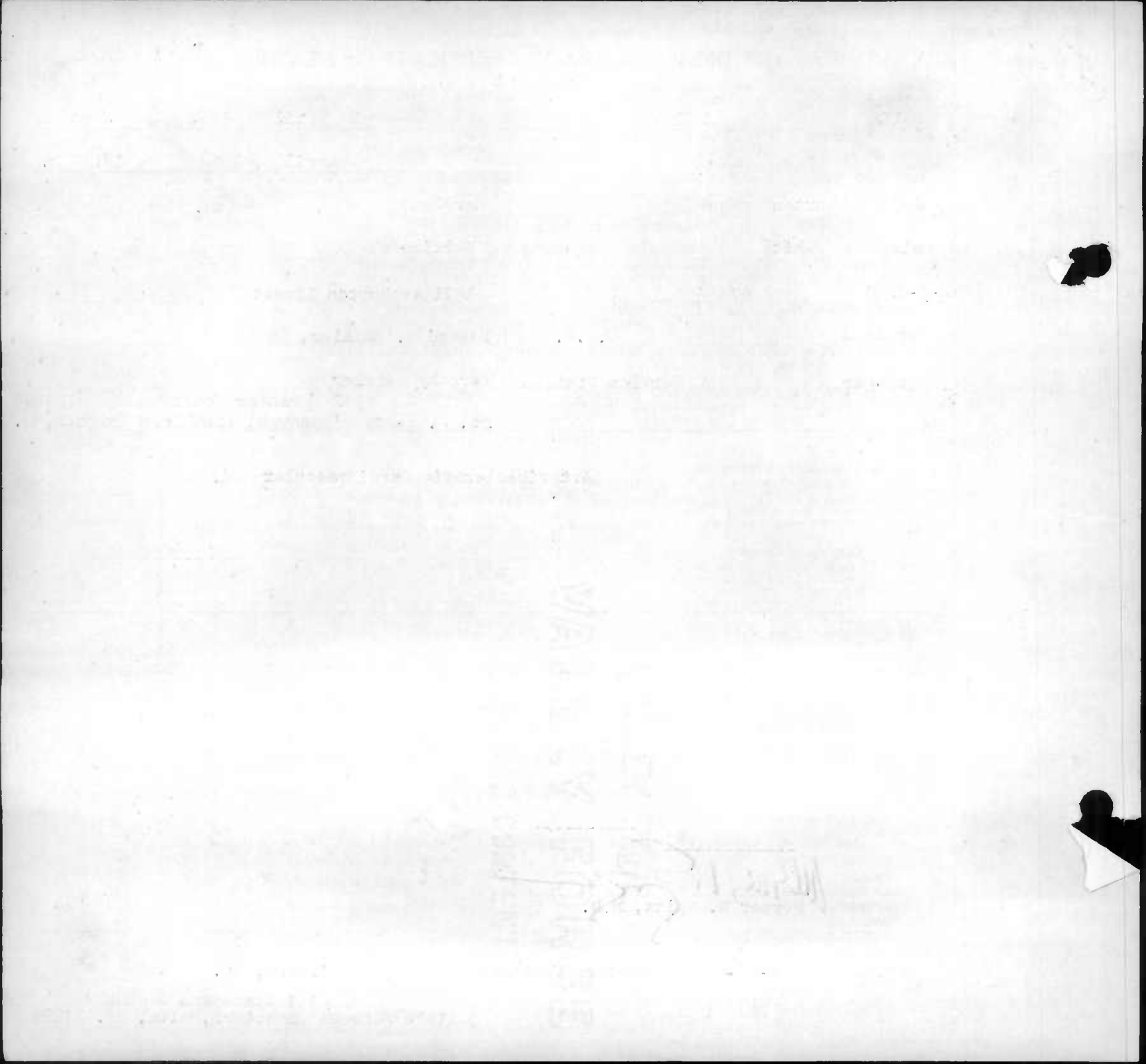
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3831

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>PAUL REISLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 8, 1968</b> Noon M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1021 Ashburton Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968 10:20 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>4-2-1901</b>	10. AGE (In years lost birthday) <b>67</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward H. Reiskler, SR</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Service Station</b>	
15. MOTHER'S MAIDEN NAME <b>Dorothy Reisler</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>512 Springer Court 21090 Mrs. J. Fahey M'Donough, Linthicum Heights, Md.</b>	
19. <b>412.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. A. DATE OF OPERATION <b>4-22-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/9/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-12-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fahey, Md</b>	
25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto, Md. 21229</b>		ADDRESS <b>4101 Edmondson Avenue</b>	



FUNERAL DIRECTOR: IMPORTANT

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68- 3832

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3832

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

High Riddick

2. DATE AND HOUR OF DEATH

April 9/68 2:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42

SINAI HOSPITAL  
OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3522 Lucille Ave

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-10-1911

9. AGE (In years last birthday)

57

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Abex Co.

11. BIRTHPLACE (State or foreign country)

Portsmouth, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph J. Riddick

14. MOTHER'S MAIDEN NAME

Edna Riddick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Frances Riddick

ADDRESS

3522 Lucille Ave

18.

226X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

UREMIA

(B) DUE TO, OR AS A CONSEQUENCE OF:

CHRONIC RENAL FAILURE many months

(C) DUE TO, OR AS A CONSEQUENCE OF:

AMYLOIDOSIS several years

289.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD

many years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/2 19 68 to 4/9 19 68, that (I) (we) last saw the deceased alive on 4/9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Katon M.D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-13-68

24C. NAME OF CEMETERY or CREMATORY

Lincoln Cem.

24D. LOCATION

Portsmouth, Virginia

25A. DATE REC'D BY HEALTH DEPT.

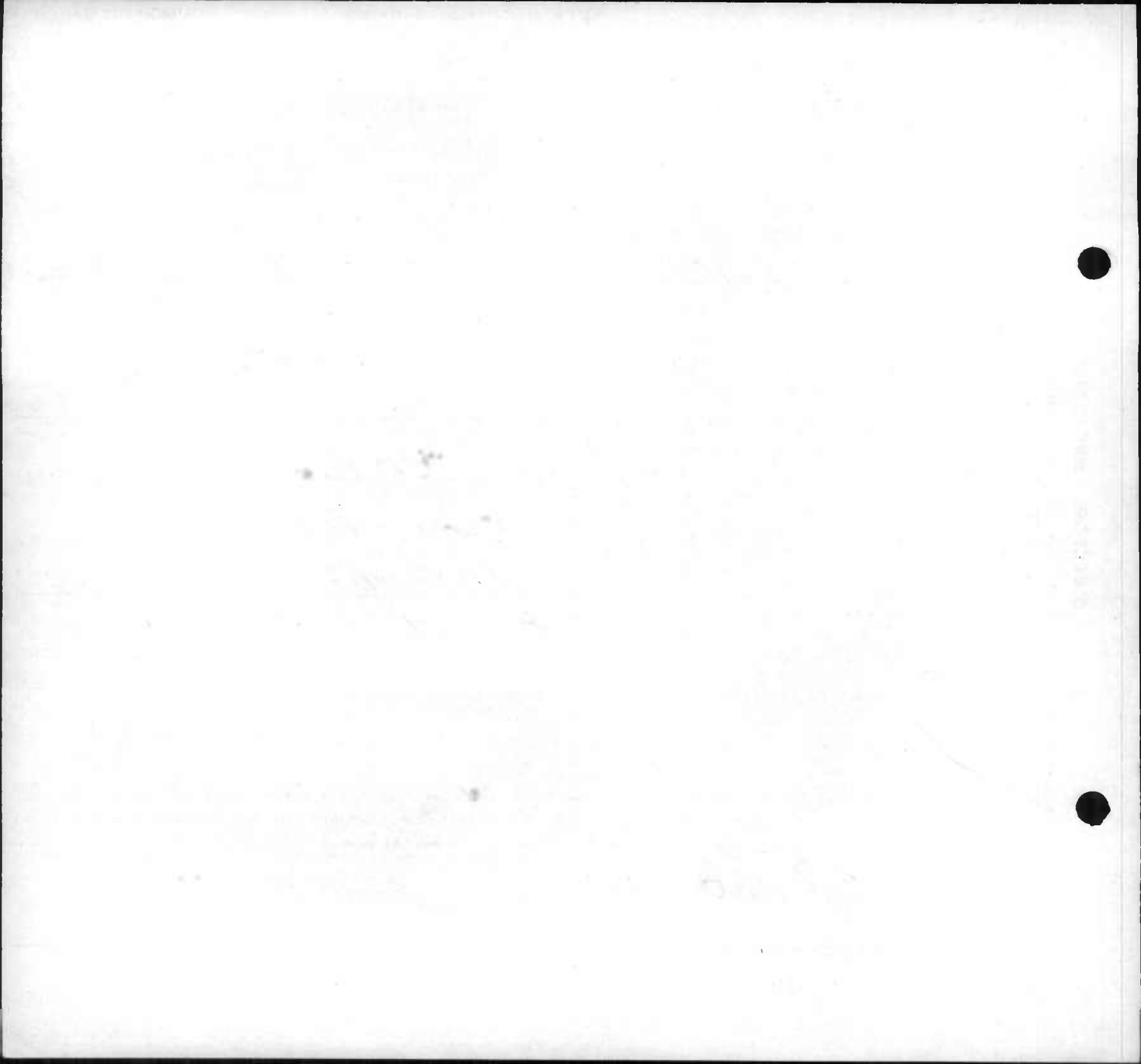
APR 10 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Morton E. Pyett F.H. 1701 Laurens St



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>VICTORIA TAYLOR YOUNG</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 8, 1968</b> Hour: <b>1:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Hopkins Hospital</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968 4:42 P.M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-15-1967</b>		10. AGE (In years lost birthday) <b>16 months</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Green</b>		14. STREET AND NUMBER <b>2125 Llewelyn Avenue</b>	
15. MOTHER'S MAIDEN NAME <b>Sarah Young</b>		16. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
17. SOCIAL SECURITY NO. <b>-0-</b>		18. INFORMANT <b>Mrs. Sarah Young</b>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		ADDRESS <b>2125 Llewelyn</b>	
19. CAUSE OF DEATH <b>484X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Interstitial Pneumonitis (SDII)</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>525X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/9/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-11-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mount Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

Handwritten signature or initials.

VALLEY FISH

VALLEY FISH

VALLEY FISH

1  
S-313

68- 3834 BALTIMORE CITY HEALTH DEPARTMENT

68- 3834

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM V. STEPTER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>April 8, 1968</b> 7:50 A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1200 Blk. St. James St. (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968</b> 7:50 A M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-25-1923</b>	10. AGE (In years last birthday) <b>44</b>	E. STREET AND NUMBER <b>828 N. Dallas Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Eddyville, Virginia</b>		13. FATHER'S NAME <b>Vernon A. Stepter</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Blanch Stepter</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Eunice Griffin</b>		ADDRESS <b>1456 N. Carey</b>	
19. <b>E 970X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Gunshot wound of Chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1200 Blk. of St. James St.</b>		22D. TIME OF INJURY (APPROX.) <b>4 8 68 7:30 A</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. shot by police</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-8-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-12-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>R. E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St</b>	

WALL L E A

*[Handwritten signature]*

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3835

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>STAN TYRONE WILEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 4, 1968</b>		Hour <b>5:00 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 4, 1968</b>		Hour <b>5:00 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		6. CITY OR TOWN <b>Baltimore</b>			
7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. SEX <b>Male</b>			
9. RACE <b>Negro</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
11. DATE OF BIRTH <b>4-2-1956</b>		12. AGE (In years last birthday) <b>12</b>		13. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
14. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		15. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		16. FATHER'S NAME <b>Thomas Wiley</b>	
17. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		18. KIND OF BUSINESS OR INDUSTRY		19. MOTHER'S MAIDEN NAME <b>Carolyn McFadden</b>	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO.		22. INFORMANT ADDRESS <b>Mr. Thomas Wiley 2718 W. Lanvale St.</b>	
23. CAUSE OF DEATH <b>E 9831 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hanging</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>E 974 X II</b>					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) <b>Yes</b>	
28. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2718 W. Lanvale Street</b>	
31. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>4 4 68 ? P.m.</b>		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		33. HOW DID INJURY OCCUR? <b>Subject was found hanging</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-5-68</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-7-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>	

Letter from M.E.'s office 7-22-68 M.H.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-3836

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HAROLD L. MATTHEWS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 4, 1968</b> 2:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year <b>April 4, 1968</b> 2:00 P. M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>6-1-1932</b>		10. AGE (in years lost birthday) <b>35</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES MATTHEWS</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>	
15. MOTHER'S MAIDEN NAME <b>Dorothy Matthews</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>213-26-9058</b>		18. INFORMANT ADDRESS <b>Mrs. Dorothy Little 140 S. Loudon St.</b>	
19. <b>E887X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of Liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Ellicott Drive and West Baltimore Street</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>2 4 68 8:20P</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. apparently fell while drinking</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-5-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-9-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkas</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		25D. ADDRESS <b>1701 Laurens St.</b>	

*[Handwritten signature]*

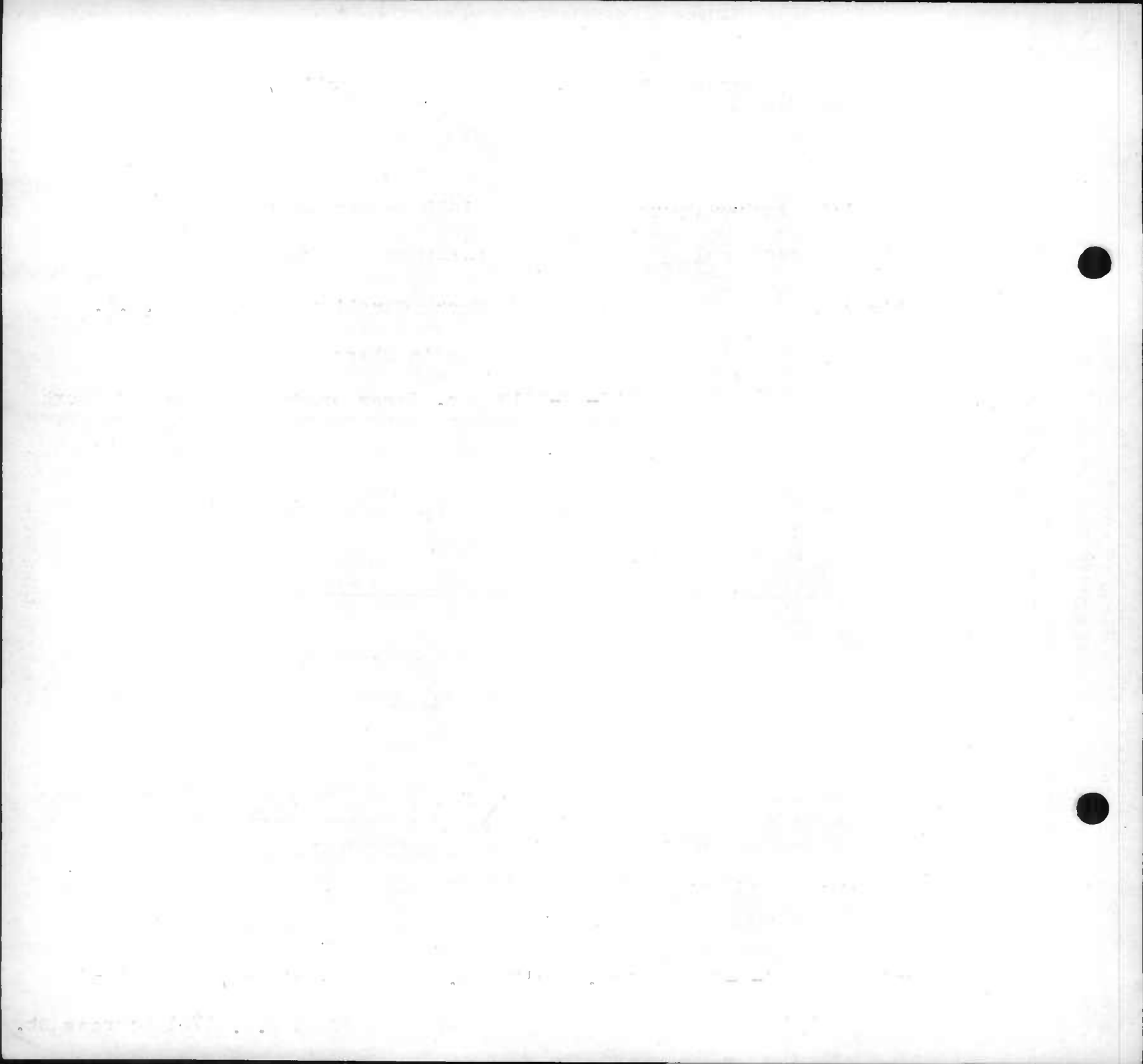
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3837 CERTIFICATE OF DEATH

REG. NO. 68- 3837

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WORTHIE JONES BROWN		April 5, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 1622 Booker Court			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 15-01
			E. STREET AND NUMBER		
			1622 Booker Court		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-4-1898	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
UNKNOWN		Addie Clark		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		215-22-5519		Mr. Jesse Brown 1622 Booker Court	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
410.9 I			Acute coronary occlusion sudden		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			cardiovascular disease one year		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
420.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-3-1967 to 4-5-1968, that (I) (we) lost saw the deceased alive on 3-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William H. Watts				4-5-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
W. Brown H. Watts				5154 Arlington Ave. Md 21223	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-8-68		Balto. Nat'l Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 10 1968		Robert E. Farber		MORTON & DYETT F.H. 1701 Laurens St.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Frederick (Douglass) Chase</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>April 6, 1968</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968</b> <b>2:00 A</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>1-18-1942</b>		10. AGE (In years last birthday) <b>26</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-36-5749</b>	
18. INFORMANT <b>Mrs. Eltra Nelson</b>		ADDRESS <b>1814 Etting St.</b>	
19. <b>E 966 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Stabwound of chest</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22D. TIME OF INJURY (APPROX.) <b>4-6-68 1:30 A</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>538 Laurens St.</b>		22F. HOW DID INJURY OCCUR? <b>Stabbed by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>4-6-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-10-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

(Continued)

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WATLIX FOR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(Ashley) WILLIAM A. SMITH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 11:27 A.M.</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>9-14-1917</b>		10. AGE (In years last birthday) <b>50</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Dunn, North Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	E. STREET AND NUMBER <b>11 N. Culver Street</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Coast Guard</b>		15. MOTHER'S MAIDEN NAME <b>Mary Smith</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>218-10-8860</b>	18. INFORMANT ADDRESS <b>Mrs. Doris Smith 11 N. Culver St.</b>
19. <b>410.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Hypertensive and arteriosclerotic cardiovascular disease with acute myocardial infarction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>4-10-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Baltimore Nat'l Cem.</b>	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>4-10-68 11:27</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Myocardial infarction</b>		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-10-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3840  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JULIA YOUNG</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 4, 1968</b> 6:25 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1003 N. Parrish Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 4, 1968</b> 6:25 P. M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>2-3-1929</b>		10. AGE (In years lost birthday) <b>39</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Accomack Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>WILLIAM BAGWELL</b>		15. MOTHER'S MAIDEN NAME <b>ANNIE GLENN</b>	
18. INFORMANT <b>Mr. Sam Young</b>		ADDRESS <b>1003 Parrish St.</b>	
19. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Esophagus</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-5-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-11-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>John E. Fe...</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

*[Handwritten signature]*  
[Illegible text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3841

CITY HEALTH DEPARTMENT  
BALTIMORE  
CERTIFICATE OF DEATH

REG. NO. 68- 3841

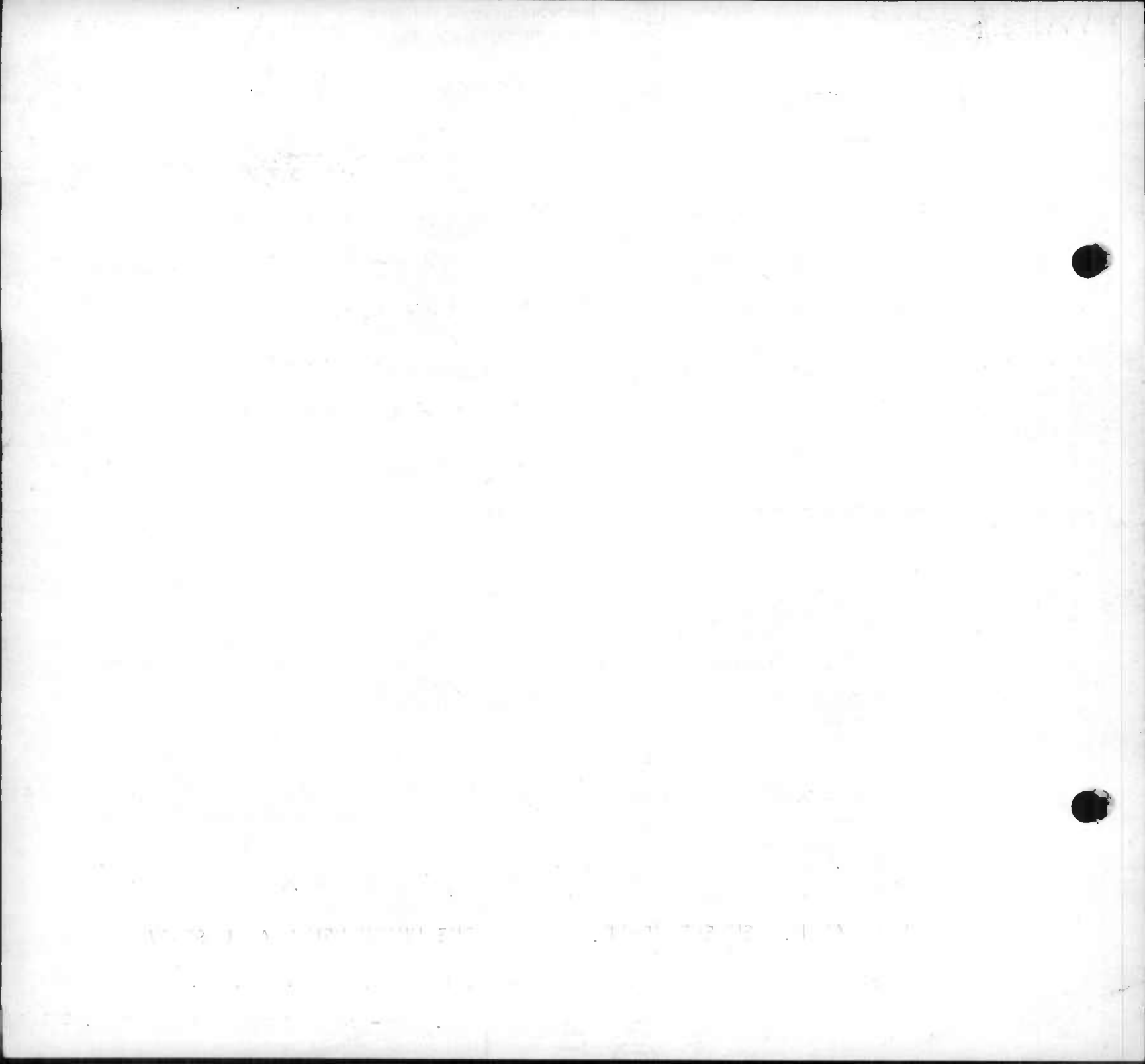
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>RACHEL E. MILLER</i>		2. DATE AND HOUR OF DEATH <i>4-9-68 8:00 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> # <i>21230</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/> E. STREET AND NUMBER <i>1725 CLARKSON</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-22-1889 78</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Thomas Harris</i>			14. MOTHER'S MAIDEN NAME <i>Catherine Amanda</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>MRS. MARY BENINGER</i>	
				ADDRESS <i>1449 COVINGTON ST. BALTO., MD. 21230</i>	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>BRONCHIOGENIC CANCER</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>PLEURAL EFFUSION</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>PULMONARY EDEMA</i> (C) <i>2 M Lobe PNEUMONIA</i>			
18. <i>162.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>4-6</i> 19 <i>68</i> to <i>4-9</i> 19 <i>68</i> , that <del>we</del> (we) lost saw the deceased alive on <i>4-9</i> 19 <i>68</i> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood, M.D.</i>				23B. DATE SIGNED <i>4-9-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Donald M. Wood, M.D.</i>				23D. ADDRESS <i>1213 Light St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-12-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>	
24D. LOCATION <i>Towson</i>		24E. CITY, TOWN, OR COUNTY <i>MARYLAND</i>		24F. STATE <i>MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Inc.</i>	
				ADDRESS <i>1217 St. Paul St. BALTO., MD. 21202</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3842	
BIRTH NO. 68-3842				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LOUISE C. McGRANAGHAN</b>		2. DATE AND HOUR OF DEATH <b>4/9/68 1 45/A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>RUXTON BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1511 MALVERN AVE 53-00</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/17/22</b>	9. AGE (In years last birthday) <b>45</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>EARLE WITHGOTT</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE CRANE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-12-6365</b>		17. INFORMANT <b>DAVID E. McGRANAGHAN 1511 MALVERN AVE.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Undifferentiated</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bronchogenic Carcinoma</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic Undifferentiated</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchogenic Carcinoma</b> (C) _____			
18. <b>162.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3/15</b> 19 <b>68</b> to <b>4/9</b> 19 <b>68</b> , that (I) <del>was</del> last saw the deceased alive on <b>4/8</b> 19 <b>68</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>W. H. Oehlert Jr MD.</b>				23B. DATE SIGNED <b>4/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. OEHLERT JR MD.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION <b>Pikesville, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3843

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 3843

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Josephine E. Fernandes

2. DATE AND HOUR OF DEATH

April 4, 1968 6 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

119 S. Conkling

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

119 S. Conkling

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

3/6/1894

9. AGE (In years last birthday)

74

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Kriener

14. MOTHER'S MAIDEN NAME

UNK.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-12-5880

17. INFORMANT

Mr. William Fernandes - same

ADDRESS

18. 4/10/9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis

(B) Anterior-sclerosis

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 hrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1/68 196 to 4/4 1968. that (I) (we) last saw the deceased alive on 4/2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.

23A. SIGNATURE

Charles F. Flom M.D.

DEGREE

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

4/7/68

23C. PHYSICIAN'S NAME (Type)

Dr. Chas. Flom

DEGREE

23D. ADDRESS

3123 Eastern Ave - Balto. Md - 21204

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/8/68

24C. NAME OF CEMETERY or CREMATORY

Gardens of Cem.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 10 1968

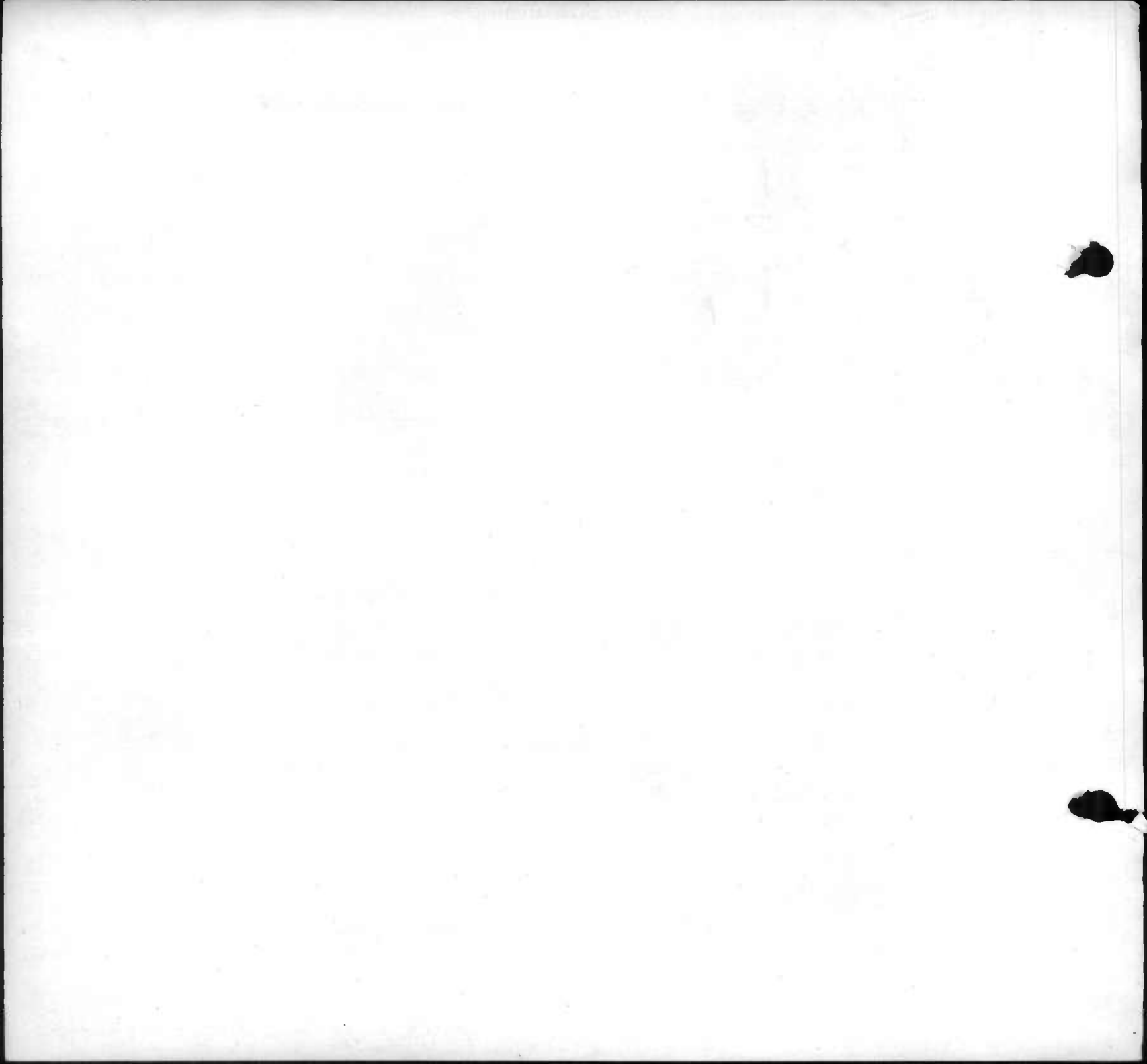
25B. NAME OF REGISTRAR

Robert E. Jackson, M.D.

25C. FUNERAL DIRECTOR

Joseph N. Zannino 203 S. Conkling St

ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3844

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3844

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES T. MURRAY</b>		2. DATE AND HOUR OF DEATH <b>APRIL 9 1968 9:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> (In case of death in hospital or institution, give street address or location) <b>UNIVERSITY OF MARYLAND</b> <b>4-16-68</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>S-01</b>		C. CITY OR TOWN: <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>2/12/24</b>		9. AGE (In years last birthday) <b>44</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SMALL BUSINESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RECREATION HALL</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Levi - Murray</b>		14. MOTHER'S MAIDEN NAME <b>EVELYN Dillinger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW. II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Suhomlin</b> <b>Mrs. Elena Murray same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SHOCK 2° A</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
19. DATE OF OPERATION <b>420.1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>APRIL 6 1968</b> to <b>APRIL 9 1968</b> , that (1) (we) last saw the deceased alive on <b>APRIL 9 1968</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>William H. Braker, Jr. MD</b> 23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. BRAKER, JR. MD</b>	
23B. DATE SIGNED <b>4/9/68</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL BALTIMORE MD.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>4/13/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Andrews Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	

V.S. 153

4-16-68

M.H.

M-600

68-- 3845

CITY OF BALTIMORE  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

REG. NO. 68- 3845

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MEYER, JANE, K.

2. DATE AND HOUR OF DEATH

4/9/68

8:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3/Balto. City Hospit. 21224  
4940 Eastern Avenue, Baltimore, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md.

Baltimore county

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

235 Gaywood Rd. 53-27204

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3-22-21

9. AGE (In years  
last birthday)

47

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Physician, School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Rhode Island

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John C. Knowles

14. MOTHER'S MAIDEN NAME

Louise Emerson

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: B-1-4940 Eastern Avenue 21224

18.

223.2 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, oshtenio, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Pulm. Emboli

1 wk.

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.

(B) SEVERE BRAIN DAMAGE DUE TO

DUE TO, OR AS A CONSEQUENCE OF:

(C) St. following Craniotomy for Intracranial Meningeoma 1 1/2

MEDICAL CERTIFICATION

223 X II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

Jan-26-1967

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED  
intracranial meningioma

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

ho.

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While ☐  
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4/67 1967 to 4/9/67 19  
that (I) (we) last saw the deceased alive on 4/9/68 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Mayersdorf M.D.

Attending ☒  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4/9/68

23C. PHYSICIAN'S  
NAME (Type)

ASSA MAYERSDORF M.D.

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

24B. DATE

4/10/68

24C. NAME OF CEMETERY or CREMATORY

Greenmount Crematory

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 10 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

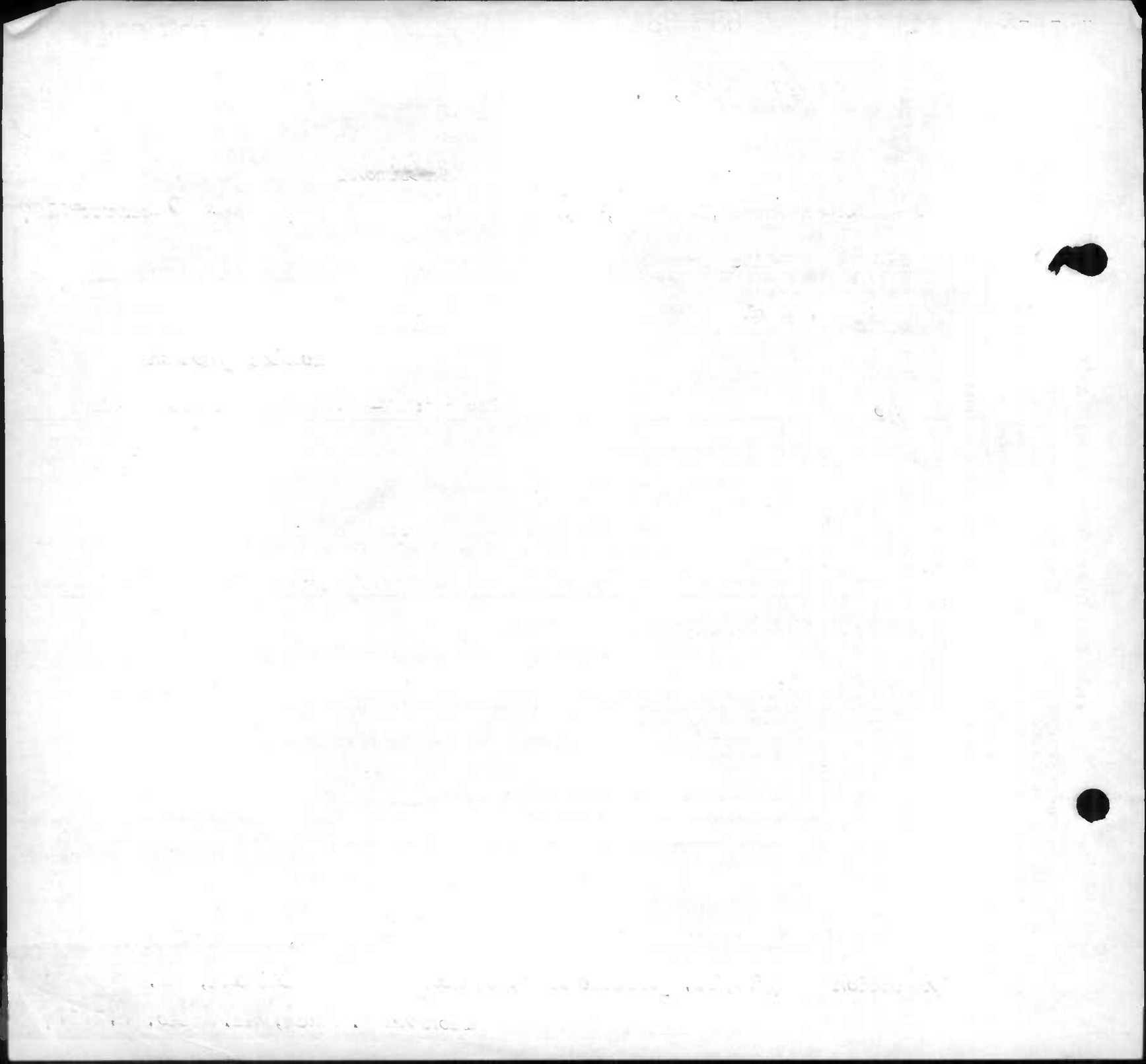
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3846

CERTIFICATE OF DEATH

REG. NO. 68- 3846

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN W. GILBERT, Jr.</b>		2. DATE AND HOUR OF DEATH <b>4. 9. 68 2 a M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-06</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Union Memorial Hospital</b>		E. STREET AND NUMBER <b>6207 Fair Oaks Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5. 29. 24</b>	9. AGE (In years last birthday) <b>43</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Gilbert Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Edna M. Carre</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>220-12-6118</b>		17. INFORMANT <b>Mrs. Edna M. Gilbert</b> ADDRESS <b>(Same)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary edema</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Corrosion of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Corrosion of liver</b>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>581.0 II</b>			
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>4-5-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9. E Bleeding</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>3-28-68</b> to <b>4-9-68</b> , that (B) (we) last saw the deceased alive on <b>4-9-68</b> and that in (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Felix J Martin</b>		23B. DATE SIGNED <b>4-9-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR FELIX J MARTIN</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/12/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbairn</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>			

1875

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68-3847

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOAN CHRISTOPHER SMELTZER</b>		2. DATE AND HOUR OF DEATH <b>4-8-68</b>   <b>5 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>UNION MEMORIAL HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSP.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>7710 Old Harford Rd.</b>		5. SEX <b>F</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-12-43</b> 9. AGE (In years lost birthday) <b>24</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RECEPTIONIST</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>BENJAMEN CHRISTOPHER</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN REBSTOCK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-42-6398</b>		17. INFORMANT ADDRESS <b>MRS. LILLIAN CHRISTOPHER - 7710 OLD HARFORD RD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>3-7-68 I</b> <b>Cirrhosis of liver</b> <b>Splenomegaly - 830 Gm</b> <b>Hemorrhage - peritoneal cavity</b> <b>MCT</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (8) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>3-8-68 II</b>					
19A. DATE OF OPERATION <b>4-5-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GI Bleeding</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>403</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>4-03</b> 19 <b>68</b> to <b>4-08</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Felix E. Martin</b>				23B. DATE SIGNED <b>4-8-68</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>The Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/12/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 10 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				B-620 68-3848		CITY HEALTH DEPARTMENT		REG. NO. 68-3848	
1. NAME OF DECEASED (Type or Print) <i>Gertrude I. Burck</i>				2. DATE AND HOUR OF DEATH <i>April 8, 1968</i> <i>2:30 A. M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4228 Parkside Drive</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>				6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 11, 1907</i>	
9. AGE (In years last birthday) <i>60</i>				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Billing Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Standard Distillers</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>John Ruppert</i>				14. MOTHER'S MAIDEN NAME <i>Mary Gilroy</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-10-7113</i>		17. INFORMANT <i>Frank A Burck-4228 Parkside Drive -21206</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Edema</i>				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION lost. <i>Cardio-Vascular Hypertensive Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diabetes</i>				21. DATE OF OPERATION <i>4/3/68</i>				22. DATE OF OPERATION <i>4/3/68</i>	
23. DATE OF OPERATION <i>4/3/68</i>				24. CONDITION FOR WHICH OPERATION WAS PERFORMED				25. AUTOPSY? (Yes or No)	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				31. HOW DID INJURY OCCUR?	
32. I certify that (I) (the hospital) attended the deceased from <i>July 1956</i> to <i>April 8, 1968</i> , that (I) lost saw the deceased alive on <i>March 14, 1968</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (view) the body after death.				33. SIGNATURE <i>Michael J. Dausch</i> M.D. DEGREE				34. DATE SIGNED <i>April 8, 1968</i>	
35. PHYSICIAN'S NAME (Type) <i>Michael J. Dausch</i>				36. ADDRESS				37. DATE	
38. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				39. DATE <i>4-10-68</i>				40. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
41. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>				42. DATE REC'D BY HEALTH DEPT. <i>APR 10 1968</i>				43. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
44. FUNERAL DIRECTOR <i>John C. Miller Inc. -6415 Belair Road-21206</i>				45. ADDRESS				46. DATE	

2. A.

3. B.

4. C.

5. D.

6. E.

7. F.

8. G.

9. H.

10. I.

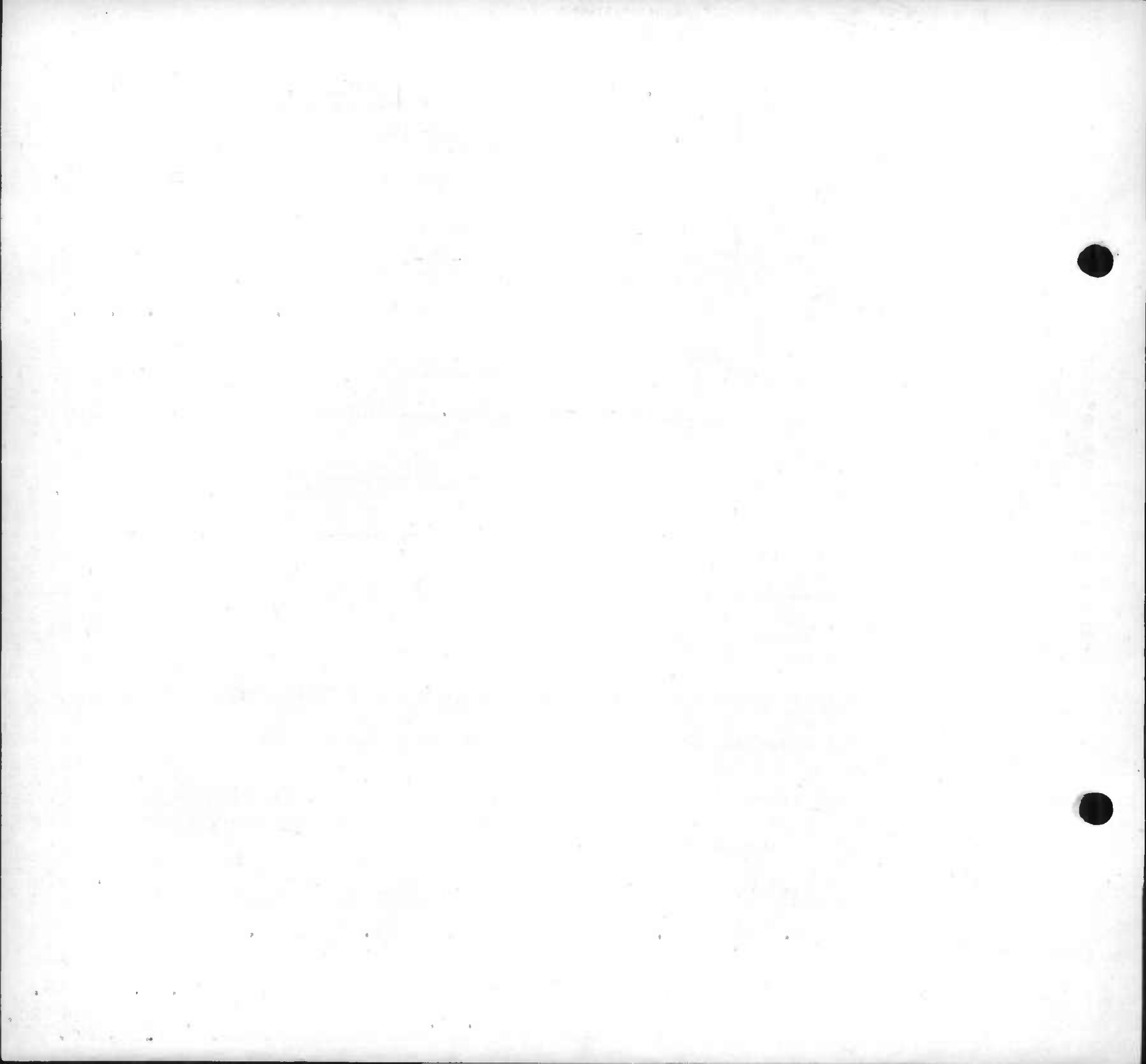
11. J.

12. K.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68- 3849	
BIRTH NO. <u>M-620</u>				68- 3849			
1. NAME OF DECEASED (Type or Print) <u>George R. Morris</u>				2. DATE AND HOUR OF DEATH <u>April 9, 1968</u> <u>8:30 A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>218 Wendover Road</u>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>218 Wendover Road</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1877</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Luraysville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Morris</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-1732</u>		17. INFORMANT <u>Mrs. Lillian McNair Morris</u>		ADDRESS <u>(Same)</u>	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>450.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <u>4/11/68</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Genl. Arterio Sclerosis 1-2 yrs</u> (B) <u>Age</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1968</u> to <u>April 9, 1968</u> , that (I) (we) lost saw the deceased alive on <u>April 8, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE <u>Walter A. Baetjer</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-9-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Walter A. Baetjer</u>				23D. ADDRESS <u>1010 St. Paul St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>			



Released or approved by Medical Examiner (Co. Henry)

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GEORGE W. MILLER		APRIL 8, 1968 2:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL		BALTIMORE 18		3718 GREENMOUNT AVE. (CITY)	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
M		W		8. DATE OF BIRTH	
				10/14/84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
RETIRED - ENGINEER - STEEL		BETHLEHEM		83	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
UNKNOWN		GEORGE W. MILLER		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN		214-81-8888		H. FORD WHEEDEN, 1525 E 29th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				GRAM NEG. SEPSIS	
				PNEUMONIA	
				MULTIPLE FRACTURES	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
3/31/68		FX R HIP			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		HOME		3718 GREENMOUNT AVE.	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
3/29/68 9:00 PM		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		FELL OVER RAILING AT HOME	
22. I certify that (1) (this hospital) attended the deceased from 4/8/68 to 4/8/68 and that (2) (we) last saw the deceased alive on 4/8/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) did (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
P. Dickson Jones, MD.				4/8/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/12/68		Lorraine Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 11 1968		H. W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	

BALTIMORE 18

M

BRIDGE  
UNKNOWN

UNKNOWN

318 GREENWICH

BALTO

318 GREENWICH

10/14/84 83

NEW YORK  
UNKNOWN

ADA

GRANITE 2422

INDONESIA

MULTIPLE FRANCHISES

HOME  
FIRE HIB

2/31/88

2/24/88

2/16/88

Mr. Johnson from New York

318 GREENWICH

10/11/82 FOR EVER ENGINE

0

0

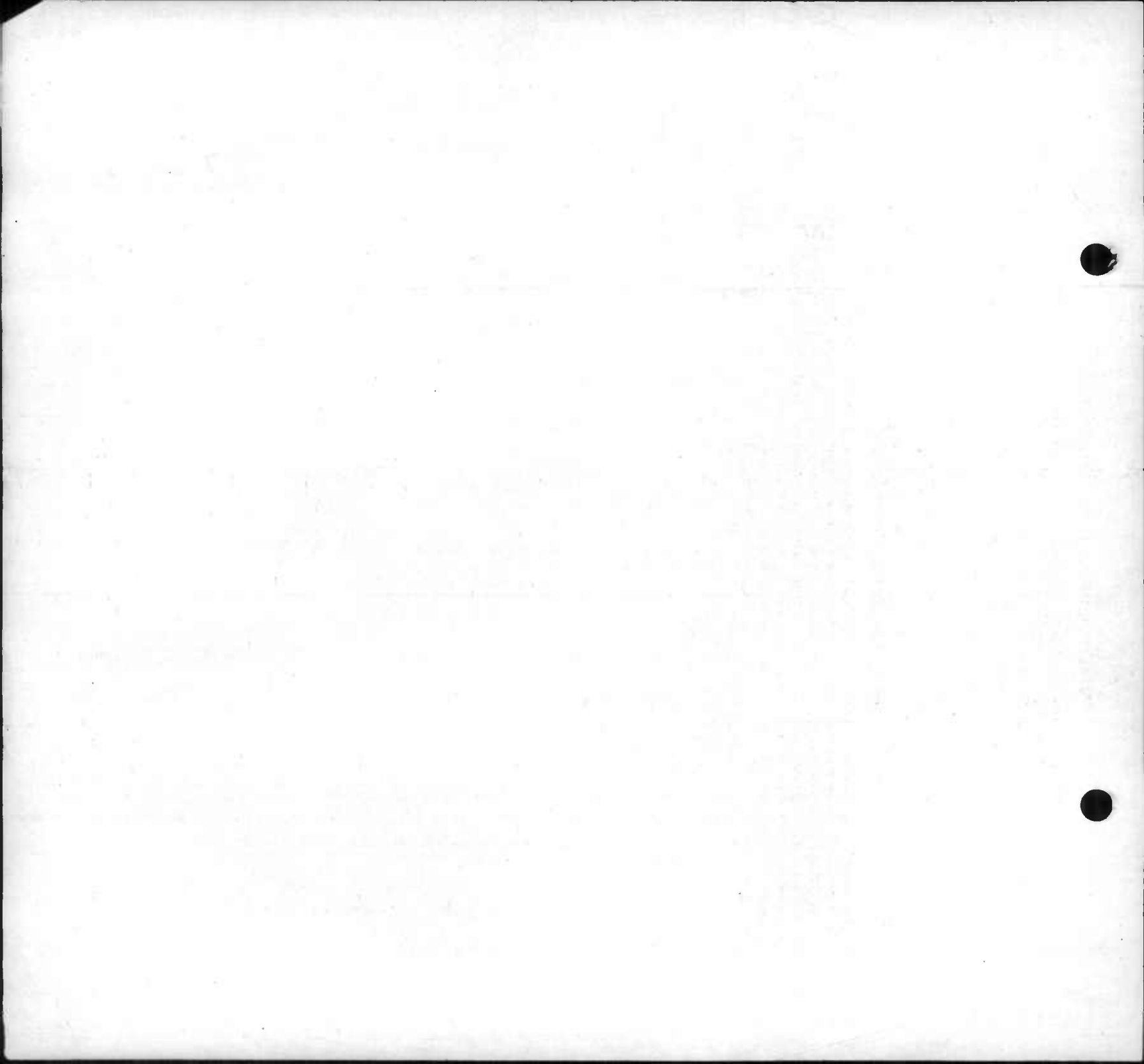
2/18/82

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-3851
BIRTH NO. 68-3851		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>John Ohlma Herbold</u>		2. DATE AND HOUR OF DEATH <u>4-6-68</u> <u>6<sup>33</sup></u> <u>A.</u> <u>M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>6</u> <u>Charlottesville</u> <u>Place</u> , <u>Baltimore</u> , <u>md.</u> <u>18</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore Public Health Service Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> <u>INSIDE CITY LIMITS?</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>6</u> <u>Charlottesville</u> <u>Place.</u>		
5. SEX <u>male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-51</u> <u>16</u>	9. AGE (In years last birthday) <u>16</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harold Harbold</u>		
14. MOTHER'S MAIDEN NAME <u>Emily Proctor</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>O. Blumery, M.D.</u>		
ADDRESS <u>USPHS Hospital Baltimore.</u>		18. CAUSE OF DEATH <u>204.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>204.4 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>---</u> 20A. AUTOPSY? (Yes or No) <u>yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u> 21C. WHERE DID INJURY OCCUR? <u>---</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>---</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>October</u> 19 <u>67</u> to <u>April</u> <u>6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April</u> <u>6</u> , 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>O. Blumery, M.D.</u>		23B. DATE SIGNED <u>4-6-68</u>		23C. PHYSICIAN'S NAME (Type) <u>Avrum Blumery, M.D.</u>
23D. ADDRESS <u>USPHS Baltimore</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>4/9/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>DUANEY VALLEY MEMO</u>		24D. LOCATION (City, town, or county) (State) <u>TIMONIUM MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		25B. NAME OF REGISTRAR <u>Philip E. Faldut</u>		25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME 4210 BELAIR</u>

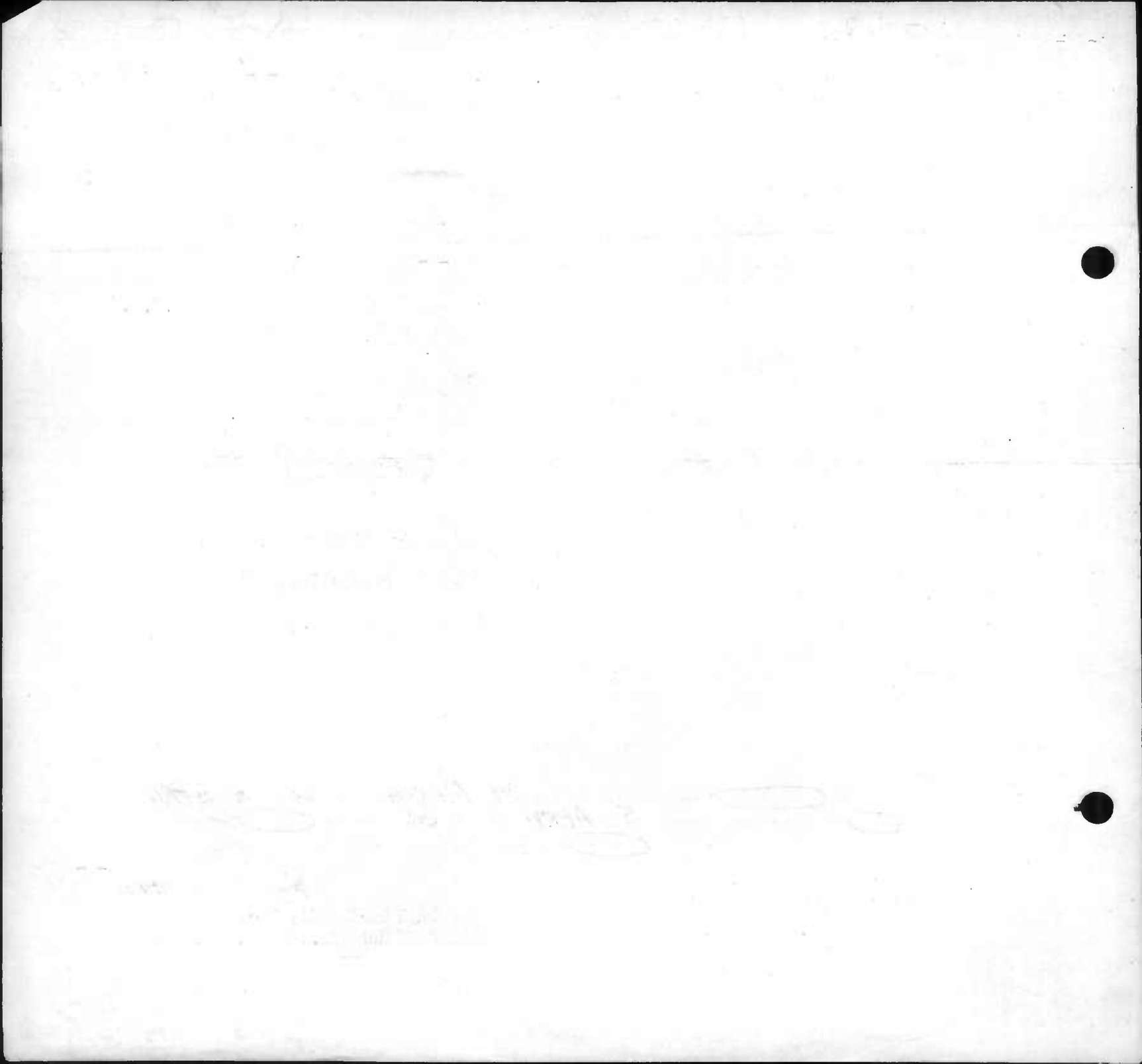


45-03-95 LB

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REC. NO.	68-3852
G-620		68-3852		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN B. GEORGE</b>		2. DATE AND HOUR OF DEATH <b>5 APRIL 1968 5:45 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVENUE</b> <b>BALTIMORE, MARYLAND #21224</b>			C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER <b>2123 DUNDALK AVE., #21224</b>			5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <b>2-8-97</b> 9. AGE (In years last birthday) <b>71</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Alexander George</b>			14. MOTHER'S MAIDEN NAME <b>MARGARITE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W I</b>			16. SOCIAL SECURITY NO. <b>234-18-0571</b>		
17. INFORMANT <b>RECORDS: Baltimore City Hospitals</b>			ADDRESS <b>4940 EASTERN AVE., BALTO., MD. #21224</b>		
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY INSUFFICIENCY</b> <b>6m NEGATIVE PNEUMONITIS</b>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>492X II HYPERTENSION</b>					
21A. DATE OF OPERATION <b>0</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <b>YES</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <b>24 MARCH</b> 19 <b>68</b> to <b>5 APRIL</b> 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>5 APRIL</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Melvin S. Tockman</b> DEGREE <b>5 APRIL 1968</b>	
23B. PHYSICIAN'S NAME (Type) <b>MELVIN S. TOCKMAN, M.D.</b>		23C. ADDRESS <b>BALTIMORE CITY HOSPITALS</b> <b>4940 EASTERN AVE., BALTO., MD. #21224</b>		23D. DATE SIGNED <b>4-5-68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Church of Christ Cemetery</b>	
24D. LOCATION <b>Shirley, W. Va.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		24F. NAME OF REGISTRAR <b>Robert E. Fadyema</b>	
24G. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		24H. ADDRESS		24I. DATE SIGNED	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 68- 3853		CERTIFICATE OF DEATH		REG. NO. 68- 3853	
1. NAME OF DECEASED (Type or Print) <u>GEORGE M. ARTHUR</u>				2. DATE AND HOUR OF DEATH <u>April 8, 1968</u> <u>1:45 AM.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Chuck Home &amp; Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>CAUC</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 15-1882</u>		9. AGE (In years lost birthday) <u>86</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Worker</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph Arthur</u>				14. MOTHER'S MAIDEN NAME <u>NAN TREADAWAY</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>233-16-714</u>		17. INFORMANT <u>BERTINE Mc DANIELS (daughter)</u>		ADDRESS <u>288-6320</u>	
18. <u>7329 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</u> <u>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
19. DATE OF OPERATION <u>334X II</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Superficial Carcinoma Occlusion</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 2</u> 19 <u>68</u> to <u>April 8</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>April 8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Chenita Henry, M.D.</u>				23B. DATE SIGNED <u>4/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>NEVITA L. SUAREZ, M.D.</u>		23D. ADDRESS <u>Chuck Home &amp; Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/10/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>SACRED HEART CEMETERY DUNDALK MD</u>		24D. LOCATION (City, town, or county) (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>Chuck Home &amp; Hospital</u>		ADDRESS <u>DUNDALK</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-- 3854 CERTIFICATE OF DEATH

REG. NO. 68-- 3854

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William J. Krauch, Sr.</i>		2. DATE AND HOUR OF DEATH <i>4-8-68 11:25 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>#21226</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		E. STREET AND NUMBER <i>4204 Fairhaven Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1910</i>	9. AGE (In years last birthday) <i>57</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroader</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>	
13. FATHER'S NAME <i>William J. Krauch</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle Gardner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-1846</i>		17. INFORMANT <i>Wm. J. Krauch, Jr., 4122 Curtis Ave., 21226</i>	
18. <i>15-7-01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the pancreas</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>3 weeks</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <i>157X II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Metastasis of the cancer to lung</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 30 1968</i> to <i>April 8 1968</i> , that (IV) (we) last saw the deceased alive on <i>April 8 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sang Yoon Rhim, M.D.</i>		23B. DATE SIGNED <i>April 8 '68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Sang Yoon Rhim, M.D.</i>		23D. ADDRESS <i>1213 Light St.</i>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial 4-11-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hgwy., A.A.Co., Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>George J. Gonce-4001 Ritchie Hgwy., Baltimore</i>	

2nd Lt. William George High  
M White

82  
Bellevue, N.Y.  
~~Bellevue, N.Y.~~

Enclosed the  
prescription

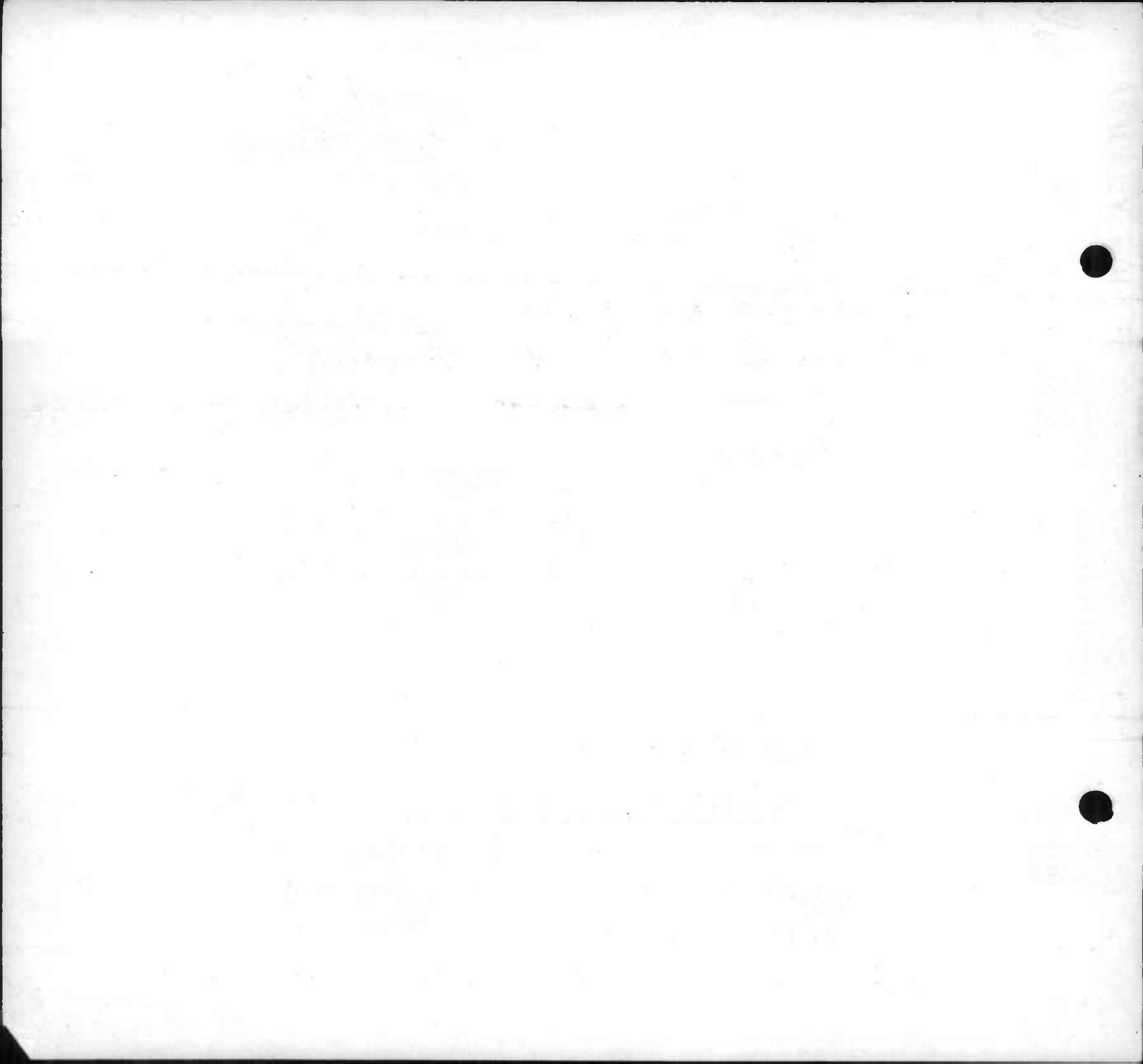
Testimony of the owner to buy  
A:

2nd Lt. John R. H. M. D.  
2nd Lt. John R. H. M. D.  
X  
2nd Lt. John R. H. M. D.  
2nd Lt. John R. H. M. D.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

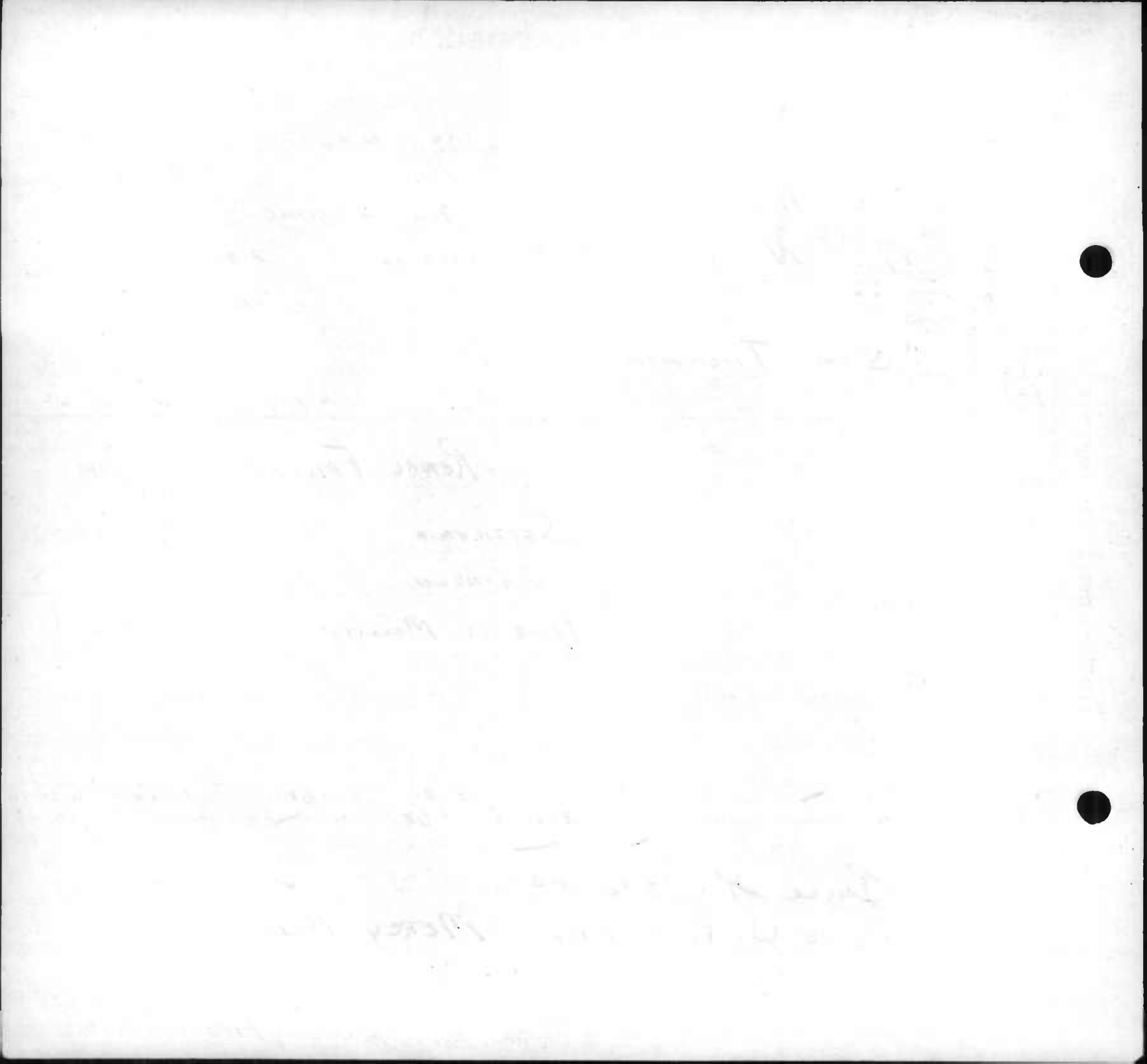
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
68-- 3855		<b>CERTIFICATE OF DEATH</b>		68-- 3855	
1. NAME OF DECEASED (Type or Print) <i>Donald C McCurley</i>		2. DATE AND HOUR OF DEATH <i>4-7-68</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Balto.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Don Secours Hospital</i>		C. CITY OR TOWN <i>BALTO.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>500</i>	
		E. STREET AND NUMBER <i>401 Maiden Choice Lane</i>			
5. SEX <i>m</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-16</i>	9. AGE (in years lost birthday) <i>52</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SURT. - RET.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CANNING FACTORY</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>James B McCurley</i>			
14. MOTHER'S MAIDEN NAME <i>Emrick</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>410-9-1250-9</i>		17. INFORMANT <i>Mrs. Donald C. McCurley - 401 Maiden Choice</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac decompensation days</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>myo Cardial Infarct. days</i> (C) <i>Hypertension &amp; diabetes years</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <i>4-10-68</i>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-23</i> 19 <i>68</i> to <i>4-7-</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-7-</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hashemi M.D.</i>		23B. DATE SIGNED <i>4-7-68</i>		23C. PHYSICIAN'S NAME (Type) <i>HASHEMI M.D.</i>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>4-10-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fawcett</i>		25C. FUNERAL DIRECTOR <i>Grady Cronan &amp; Son, Catonsville, Md.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3856</u>
T-512 68-3856				CERTIFICATE OF DEATH
BIRTH NO. _____				
1. NAME OF DECEASED (Type or Print) <u>JAMES SAMUEL THOMPSON</u>			2. DATE AND HOUR OF DEATH <u>4.10.68</u> <u>5:09</u> AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>37 MERCY HOSP.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALT. CITY</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 MERCY HOSP.</u>			C. CITY OR TOWN <u>BALT.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER <u>703 STERLING ST.</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.3.34</u>	9. AGE (In years last birthday) <u>33</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>DINWIDDIE CO. VA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>SAM THOMPSON</u>	
14. MOTHER'S MAIDEN NAME <u>DELLA ANN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO.			17. INFORMANT <u>FANNIE THOMPSON 12 N. CASTLE ST</u>	
18. <u>03891</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>DAYS</u>	
(B) <u>SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>DAYS</u>	
(C) <u>UNKNOWN</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>DIABETES MELLITUS</u>				
19A. DATE OF OPERATION <u>03314 II</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>TH</u> (this hospital) attended the deceased from <u>3.8.1968</u> to <u>3.10.1968</u> , that <u>TH</u> (we) last saw the deceased alive on <u>3.10.1968</u> and that in <u>TH</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>TH</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Bruce W. Pfeffer, M.D.</u>				23B. DATE SIGNED <u>3.10.68</u>
23C. PHYSICIAN'S NAME (Type) <u>BRUCE W. PFEFFER M.D.</u>				23D. ADDRESS <u>MERCY HOSP.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>4/11/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>DINWIDDIE MEM. PK</u>
24D. LOCATION (City, town, or county) (State) <u>DINWIDDIE CO VA</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Matthew P. Hays 638 N. C. Union St</u>		
		25D. ADDRESS <u>For Robert F. Hays PERCHERS VA</u>		



N-135+

68- 3857

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3857

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANTOINE JAMES NOVOTNY

2. DATE AND HOUR OF DEATH

APRIL 4, 1968

8:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3420 RAMONA AVE.

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

SEPT. 1, 1910

9. AGE (In years  
last birthday)

57

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

BALTO. CITY BOARD  
OF PARKS

11. BIRTHPLACE (State or foreign country)

BALTO., MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM NOVOTNY

14. MOTHER'S MAIDEN NAME

MARY SHRAMEK

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

213-05-4510

17. INFORMANT

MRS. MARIE E. NOVOTNY (SAME)

ADDRESS

18. 4-10-94-2509

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute Coronary Thrombosis

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) Atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 hr

5 yr

14 yr

MEDICAL CERTIFICATION

420.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐  
WorkNot White ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from

10 Oct

19 57

to 4 April

19 68

that (I) (we) last saw the deceased alive on

4 April

19 68

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Howard Goodman

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

5 April 68

23C. PHYSICIAN'S  
NAME (Type)

HOWARD GOODMAN

DEGREE

23D. ADDRESS

8604 HARFORD RD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-8-68

24C. NAME OF CEMETERY or CREMATORY

MOST HOLY REDEEMER

24D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Jankovic

25C. FUNERAL DIRECTOR

J. Walter Conklin 5444 BELAIR RD.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

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Handwritten text, possibly a signature or name, appearing in the lower left section of the page.

Handwritten text, possibly a signature or name, appearing in the lower middle section of the page.

Handwritten text, possibly a signature or name, appearing in the lower middle section of the page.

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S-160 1

BALTIMORE CITY HEALTH DEPARTMENT

## 68- 3858 CERTIFICATE OF DEATH

REG. NO. 68- 3858

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEROY A SPARR

2. DATE AND HOUR OF DEATH

4-8-1968 1:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND 8. COUNTY BALTIMORE

C. CITY OR TOWN KINGSVILLE 21087

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

MT. VISTA RD. 53-00

5. SEX

M

6. RACE

W

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-10-1909

9. AGE (In years)

58

(lost birthday)

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BUILDER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

ADAM SPARR

14. MOTHER'S MAIDEN NAME

CHRISTINE KAHL

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr Anne Sparr Mt. Vista Road Kingsville

18. 492X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

pulmonary infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1.0 MIN.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) CHRONIC STRAIN &amp; CONG. HEART FAIL. 2wks

DUE TO, OR AS A CONSEQUENCE OF:

(C) CHRONIC PULMONARY EMPHYSEMA 7YRS

W.K.W.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-27-1968 to 4-8-1968, that (I) (we) last saw the deceased alive on 4-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D.H. Brancato M.D.

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

4-8-1968

23C. PHYSICIAN'S NAME (Type)

DONALD H. BRANCATO MD.  
D.H. BRANCATO

23D. ADDRESS

THE UNION MEMORIAL HOSPITAL  
UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-10-1968

24C. NAME OF CEMETERY or CREMATORY

Bel Air Memorial Cemetery

24D. LOCATION

Bel Air Harford

Md

25A. DATE REC'D BY HEALTH DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Jackson

25C. FUNERAL DIRECTOR

Lassanin Funeral Home 740 Bel Air Road

ADDRESS 21236

FUNERAL DIRECTOR: IMPORTANT

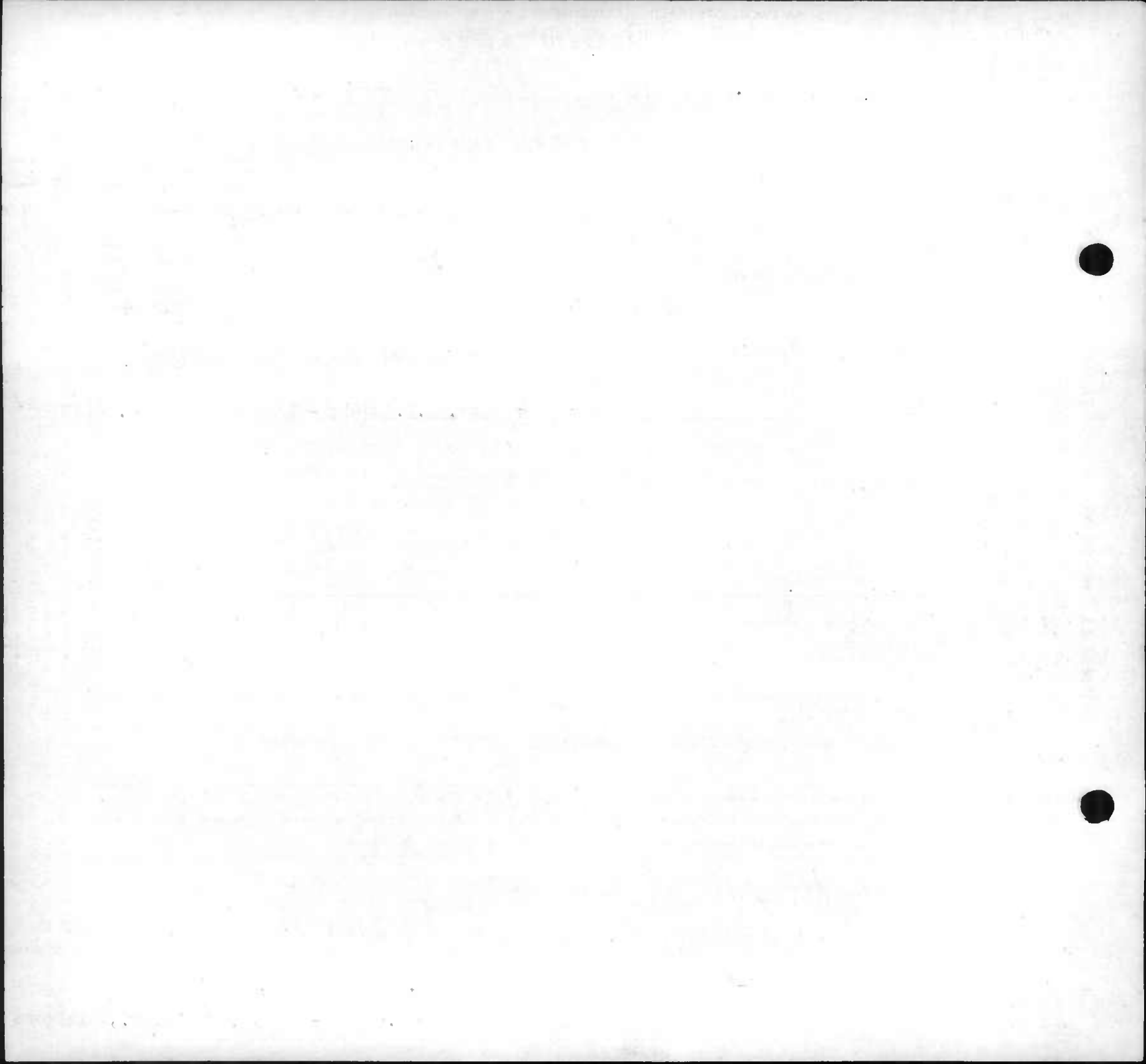
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Birth cert. for December Ann 6/10/09 in Beth. Reg. No. 449741

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3859	
68- 3859				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GARLAND C. LUDWIG</b>		2. DATE AND HOUR OF DEATH <b>4-8-68 6:45 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b> <b>36</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>2924 Rayshire Road</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-08</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTH PLACE (State or foreign country) <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN LUDWIG</b>		14. MOTHER'S MAIDEN NAME <b>ANNE NAN BASINGER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>237-01-1340</b>		17. INFORMANT ADDRESS <b>Mrs. G.C. Ludwig - 2924 Rayshire Rd. 21230</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) <b>EMPHYSEMA, SEVERE</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MASSIVE ATELECTASIS (L) LUNG</b> (B) COMPLICATING HYPERTENSIVE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOVASCULAR DISEASE</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-5-68</b> 19 to <b>4-8-68</b> 19, that (I) (we) last saw the deceased alive on <b>4-8-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Christina Abarek Feliciano, M.D.</b>				23B. DATE SIGNED <b>4-8-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHRISTINA ABAREK FELICIANO, M.D.</b>				23D. ADDRESS <b>FRANKLIN SQ. HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Faith Lutheran Church Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Salisbury, North Carolina</b>		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>George J. Gonce</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hgwy., Baltimore</b>		25D. DATE REC'D BY HEALTH DEPT.		25E. NAME OF REGISTRAR <b>George J. Gonce</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3860 CERTIFICATE OF DEATH

REG. NO. 68- 3860

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hatfield terrance E</i>		2. DATE AND HOUR OF DEATH <i>4-8-68 7:45 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i> <i>4-16-68</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>NO</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1912 Christian Street</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-6-04</i>	9. AGE (In years lost birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BLACKSMITH-WELDER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>PENNA R.R.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>James D. Hatfield</i>		14. MOTHER'S MAIDEN NAME <i>Mary M. Townsend</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>716-01-8768</i>		17. INFORMANT <i>Patient's chart</i> ADDRESS	
18. <i>1631 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ca. of the lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6:30AM 4-8 19 68</i> to <i>7:45AM 4-8 19 68</i> , that (I) (we) last saw the deceased alive on <i>7:45AM 4-8 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Byung Kap Kang</i>				23B. DATE SIGNED <i>4-8-68</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<i>BYUNG KAP KANG</i>		<i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/11/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial</i>	
24D. LOCATION (City, town, or county) (State) <i>Taylor Ave. Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT.			
<i>APR 11 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>		25C. FUNERAL DIRECTOR <i>F. B. Wippert</i> ADDRESS <i>1300 Eutaw Place</i>	

Birth Cert. A-4085 for Terence E. Hatfield  
born July 6, 1904, 50 James D. and Mary M.  
Hatfield nee Forwood 4-16-68 M.H.

E-640

68-3861

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

68-3861

Film G679 Item 13,14 9-13-91 ric

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EARLY, A Thetis -

2. DATE AND HOUR OF DEATH

4/9/68

1:20 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Balto. City Hospitals  
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4657 Delaware Ave 21215

5. SEX

Female

6. RACE

Negro

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-29-23

9. AGE (In years  
last birthday)

44

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown William Reid

14. MOTHER'S MAIDEN NAME

unknown Annie Longford

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT Baltimore City Hospitals

Records: BCH-4940 Eastern Avenue 21224

18. 3-21-9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

33/28/68

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

jaundice

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-8-19 68 to 4-9-19 68,  
that (I) (we) last saw the deceased alive on 4-9-19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Koksharia

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4/9/68

23C. PHYSICIAN'S  
NAME (Type)

A. Koksharia

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH/DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

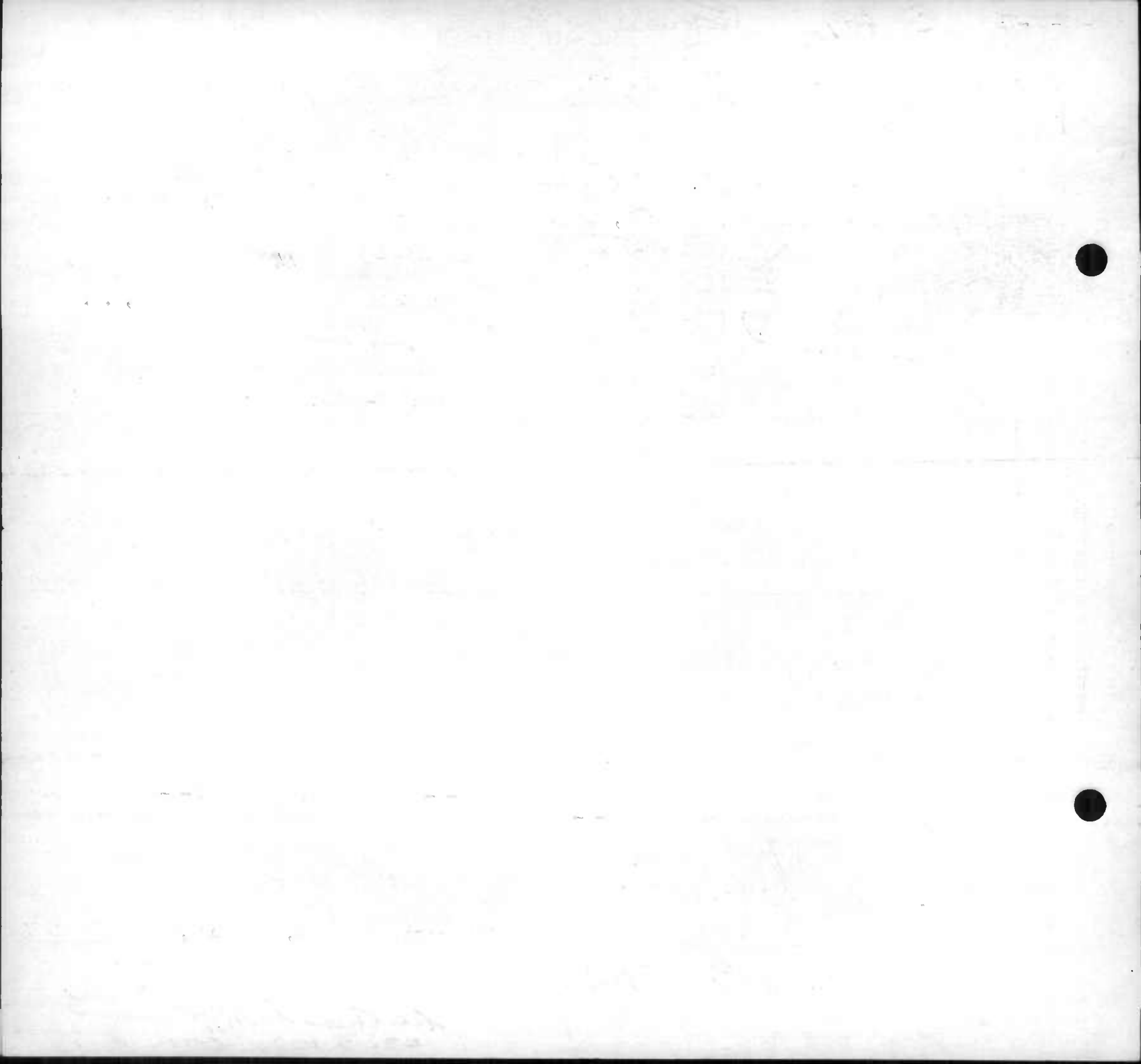
Althea L. McCann

ADDRESS

2302 W. North Ave. Baltimore

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

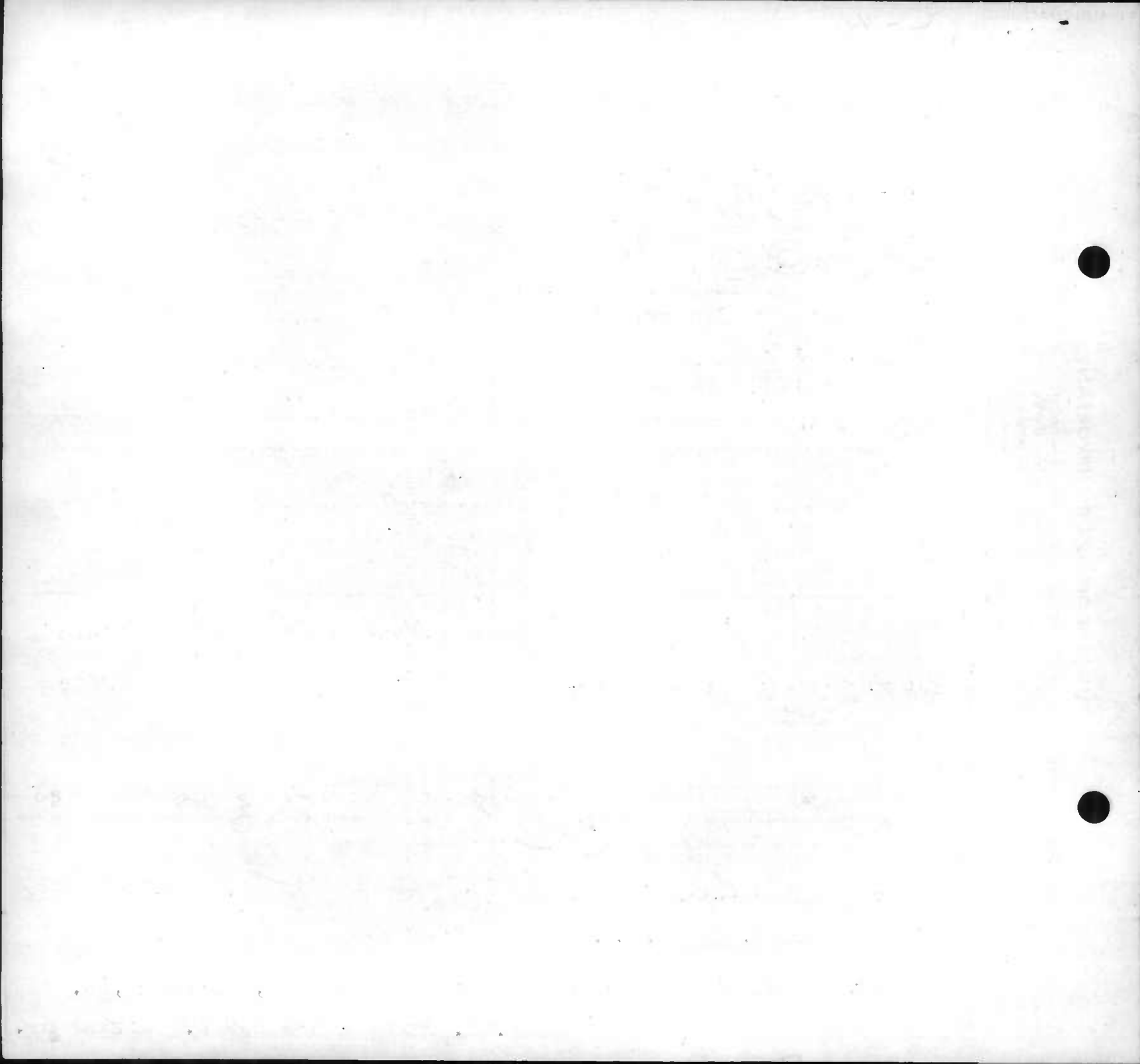
FUNERAL DIRECTOR: IMPORTANT



# FUNERAL DIRECTOR: IMPORTANT

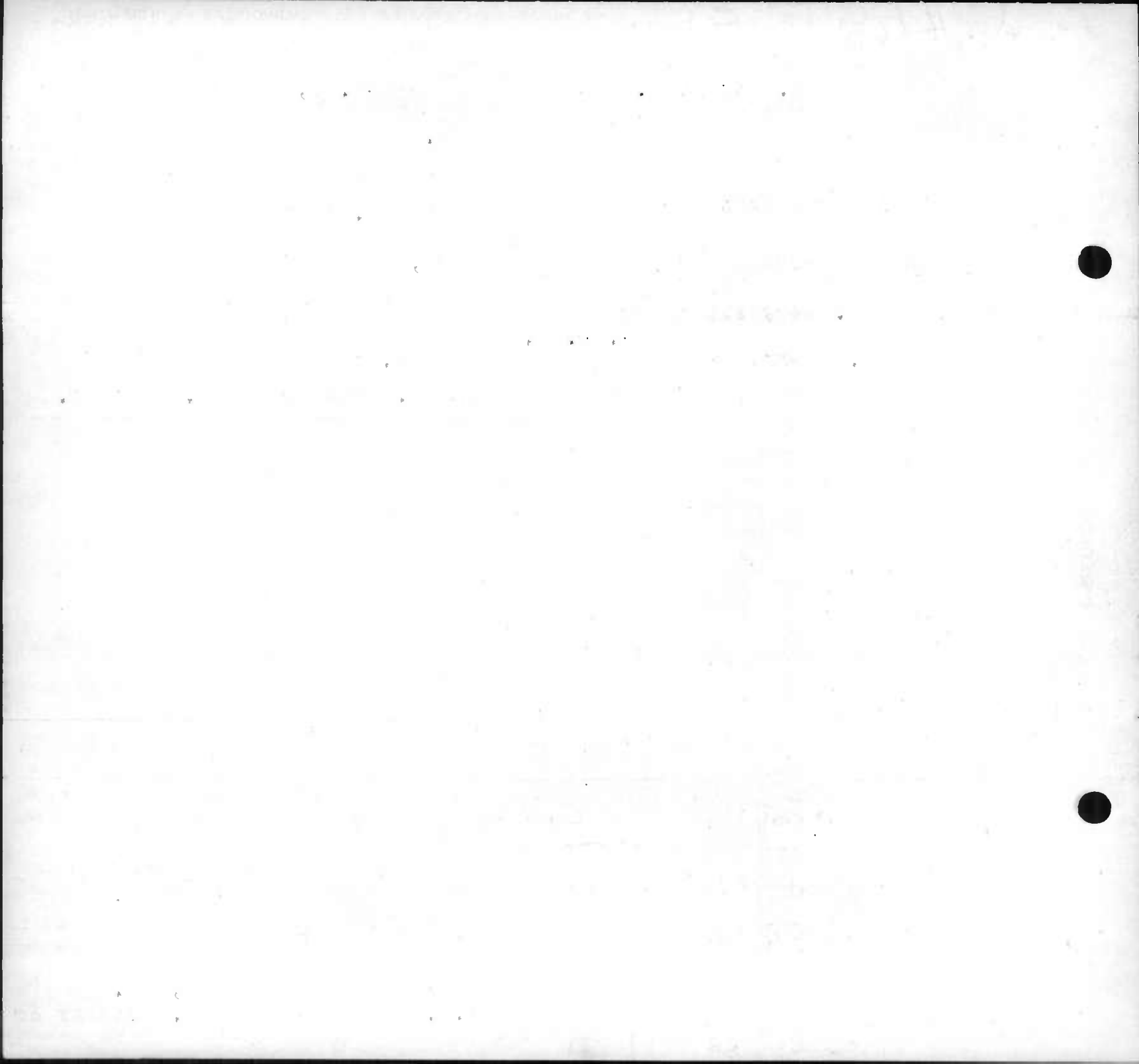
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68-3862	
C-462 68-3862		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <i>Brother John Clarke - S. J.</i>		2. DATE AND HOUR OF DEATH <i>8 April 1968 9:14 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital, Inc.</i> <i>3015 Paul Pl - 31202</i>		C. CITY OR TOWN <i>Woodstock</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
S. SEX <i>♂</i> 6. RACE <i>Caucasian</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>25 Dec 1880</i>		9. AGE (In years last birthday) <i>87</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>BROTHER OF THE JESUITE ORDER</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
13. FATHER'S NAME <i>Patrick Clarke</i>		14. MOTHER'S MAIDEN NAME <i>Rosa Cullen</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Harris J. Feldman MD</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Arteries Occlusion of C.A.D. Suggested Aneurysm.</i> (B) <i>Arteriosclerosis C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>C.D.F.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months Days Years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Arteriosclerosis Nephrosclerosis, H.C.</i>		19A. DATE OF OPERATION <i>36 Apr. 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>he</i> (this hospital) attended the deceased from <i>1 April</i> 19 <i>68</i> to <i>8 April</i> 19 <i>68</i> , that <i>he</i> (we) last saw the deceased alive on <i>8 April</i> 19 <i>68</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>he</i> (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harris J. Feldman MD</i>		23B. DATE SIGNED <i>8 April 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Harris J. Feldman, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/10/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>WOODSTOCK COLLEGE CEMETERY, WOODSTOCK, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>		25B. NAME OF REGISTRAR <i>R. E. Galt</i>		25C. FUNERAL DIRECTOR <i>H. W. MEARS &amp; SON 805 N. CALVERT ST.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3863	
BIRTH NO. 4160		68-3863	
1. NAME OF DECEASED (Type or Print) <b>Mr. ELBERT L. HUBER</b>		2. DATE AND HOUR OF DEATH <b>Apr. 5, 1968</b> 1:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1101 SAINT PAUL STREET</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1101 ST. PAUL STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 28, 1903</b> 9. AGE (In years last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED. NATIONAL ARCHIVES</b>		11. BIRTHPLACE (State or foreign country) <b>NEBRASKA</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>AMOS K. HUBER</b>		14. MOTHER'S MAIDEN NAME <b>MARY A. STROH</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARY L. HUBER</b>		ADDRESS <b>1101 ST. PAUL ST.</b>	
18. <b>1631 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>no</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1967</b> to <b>April 1968</b> , that (I) (we) last saw the deceased alive on <b>April 2 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <b>Walter B. Buck</b>		23B. DATE SIGNED <b>4/5/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER B. BUCK MD</b>		23D. ADDRESS <b>18 E. EAGER ST BALTO 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>	24B. DATE <b>4/9/68</b>	24C. NAME OF CEMETERY OR CREMATORY <b>GREENMOUNT CREMATORY</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Jarboe</b>	25C. FUNERAL DIRECTOR ADDRESS <b>H.W. MEARS &amp; SON 805 N. CALVERT ST</b>	



FUNERAL DIRECTOR: IMPORTANT

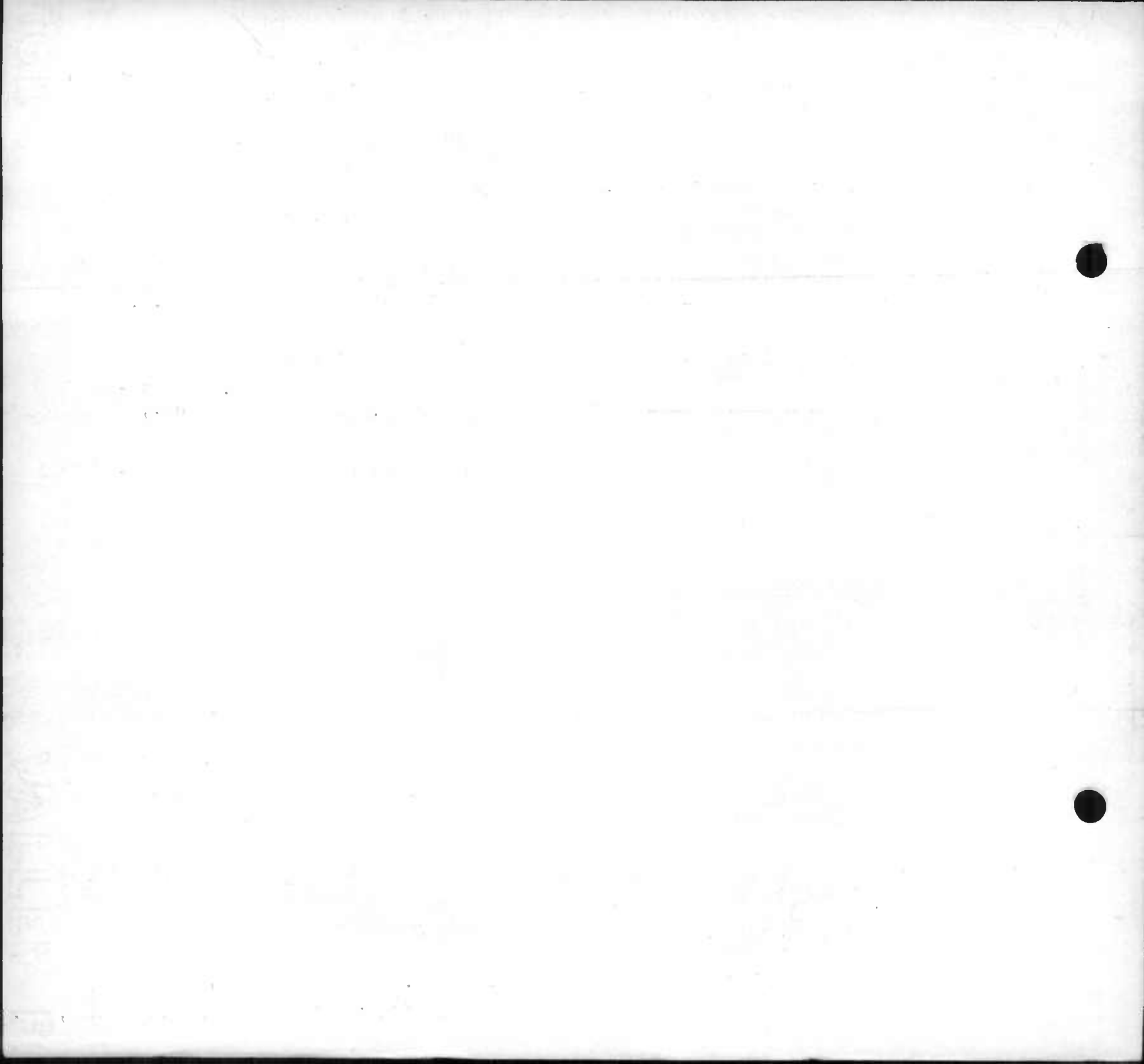
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3864

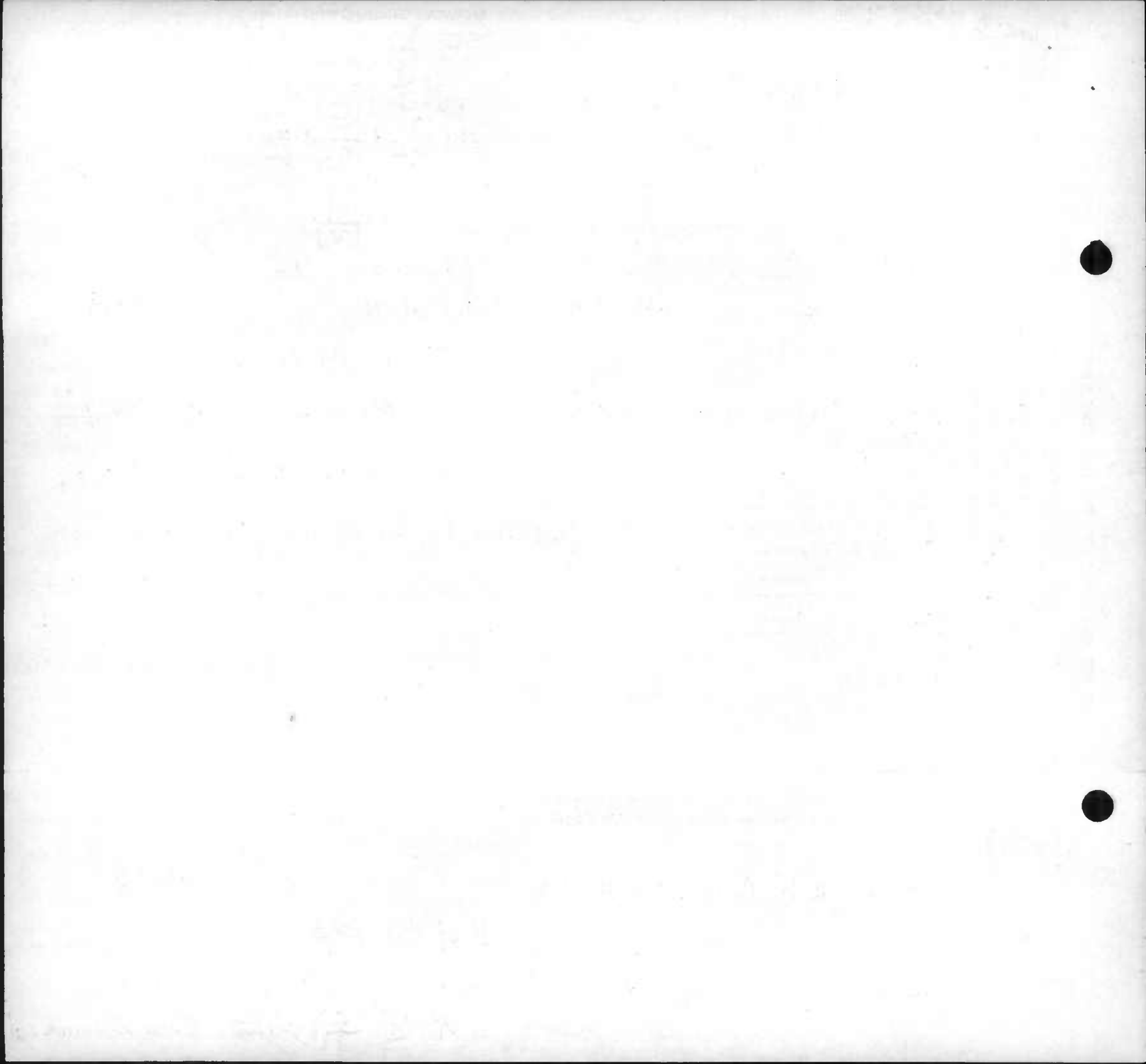
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		McCauley, Rosie A.		4/9/68 9:54 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			A. STATE Maryland B. COUNTY A.A.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Pasadena		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER Rt. 4, Box 405		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/90	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Unknown (Bukett)			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Edgar M. McCauley		
			ADDRESS Rt. 10 Box 405 Pasadena, Maryland		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4/10/91 MYOCARDIAL INFARCTION 24 HRS ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) -----		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 4/20/1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/6 1968 to 4/9 1968, that (I) (we) last saw the deceased alive on 4/9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry K. Genant MD				23B. DATE SIGNED 4/7/68	
23C. PHYSICIAN'S NAME (Type) Dr. Harry K. Genant				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/12/68		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Pk.	
				24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 11 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 3865					REG. NO. 68- 3865				
BIRTH NO.					BIRTH DATE				
1. NAME OF DECEASED (Type or Print) <u>Andrew J. Clark</u>					2. DATE AND HOUR OF DEATH <u>6/8/68</u> <u>11:15</u> <u>A</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>University</u>					A. STATE <u>Md</u> B. COUNTY <u>Anne Arundel</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Glen Burnie</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
					E. STREET AND NUMBER <u>1605 Ruskin Rd.</u> <u>52-00</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/20</u>	9. AGE (In years last birthday) <u>48</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
13. FATHER'S NAME <u>James A. Clark</u>					14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Marines WWII</u>					16. SOCIAL SECURITY NO. <u>214-05-3193</u>				
17. INFORMANT <u>Wife - Donna J. Clark</u>					ADDRESS <u>Same as above</u>				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Artery Spasm</u> <u>2 days</u>				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(B) <u>Ruptured Ant Cerebral Aneurysm @</u> <u>2 weeks</u>				
ANTECEDENT CAUSES					(C) _____				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>4/4/68</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Rupt. Aneurysm</u>				
20A. AUTOPSY? (Yes or No) <u>Yes</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				
21C. WHERE DID INJURY OCCUR? _____					(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____					21E. INJURY OCCURRED _____				
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? _____				
22. I certify that (I) (this hospital) attended the deceased from <u>3/20/68</u> 19 to <u>4/8/68</u> 19, that (I) (we) last saw the deceased alive on <u>4/7/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Frederick K. Cressman, Jr</u>					23B. DATE SIGNED <u>4/8/68</u>				
23C. PHYSICIAN'S NAME (Type) _____					23D. ADDRESS <u>U. of Md Hosp</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE _____				
24C. NAME AT CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>					25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>				
					25C. FUNERAL DIRECTOR <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie Md</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-323		68-3866		BALTIMORE CITY HEALTH DEPARTMENT		68-3866	
BIRTH NO.		CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>Hatche, William</i>				2. DATE AND HOUR OF DEATH <i>4/3/68</i> <i>3:15 PM</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Lincoln Nursing Home</i>		(If not in hospital or institution, give street address or location) <i>27 N. Carey St. Balt. Md.</i>		A. STATE <i>Maryland</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>301 S. Fremont Ave</i>		D. STREET ADDRESS (If rural, give location) <i>Baltimore</i>	
5. SEX <i>male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>3-10-1910</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>un known</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>un known</i>		11. BIRTHPLACE (State or foreign country) <i>un known</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>un known</i>				14. MOTHER'S MAIDEN NAME <i>un known</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>un known</i>		16. SOCIAL SECURITY NO. <i>un known</i>		17. INFORMANT ADDRESS <i>un known</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>433.91</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>332X II</i>				CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> 19 <i>64</i> to <i>4/3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/3</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Henric Deunaline</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/3/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Henric Deunaline</i>				23D. ADDRESS <i>930 WINTERBROOK ST. Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4/7/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fronklinston</i>		24D. LOCATION (City, town, or county) (State) <i>North Carolina</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>G. Halstead</i>		ADDRESS <i>1206 W. North</i>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3867

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CECIL RAYMOND HAILEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968 3:25 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-36</b>	
9. DATE OF BIRTH <b>Feb. 19, 1904</b>		10. AGE (In years lost birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL HAILEY</b>		14. STREET AND NUMBER <b>6583 St. Helena Avenue</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OP.</b>		15. MOTHER'S MAIDEN NAME <b>EVA POOLE</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>213-07-7613</b>	
18. INFORMANT <b>MARY I. HAILEY-WIDOW</b>		19. CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>4/12/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AS IN NO. 5 ABOVE</b>	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/12/1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>COOL SPRINGS CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>LUNENBURG CO. VIRGINIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>W. BROOKS BRADLEY, DUNDALK, MD.</b>	

513-11-113

WATLIE

*[Handwritten signature]*

12/1/5

FUNERAL DIRECTOR: IMPORTANT

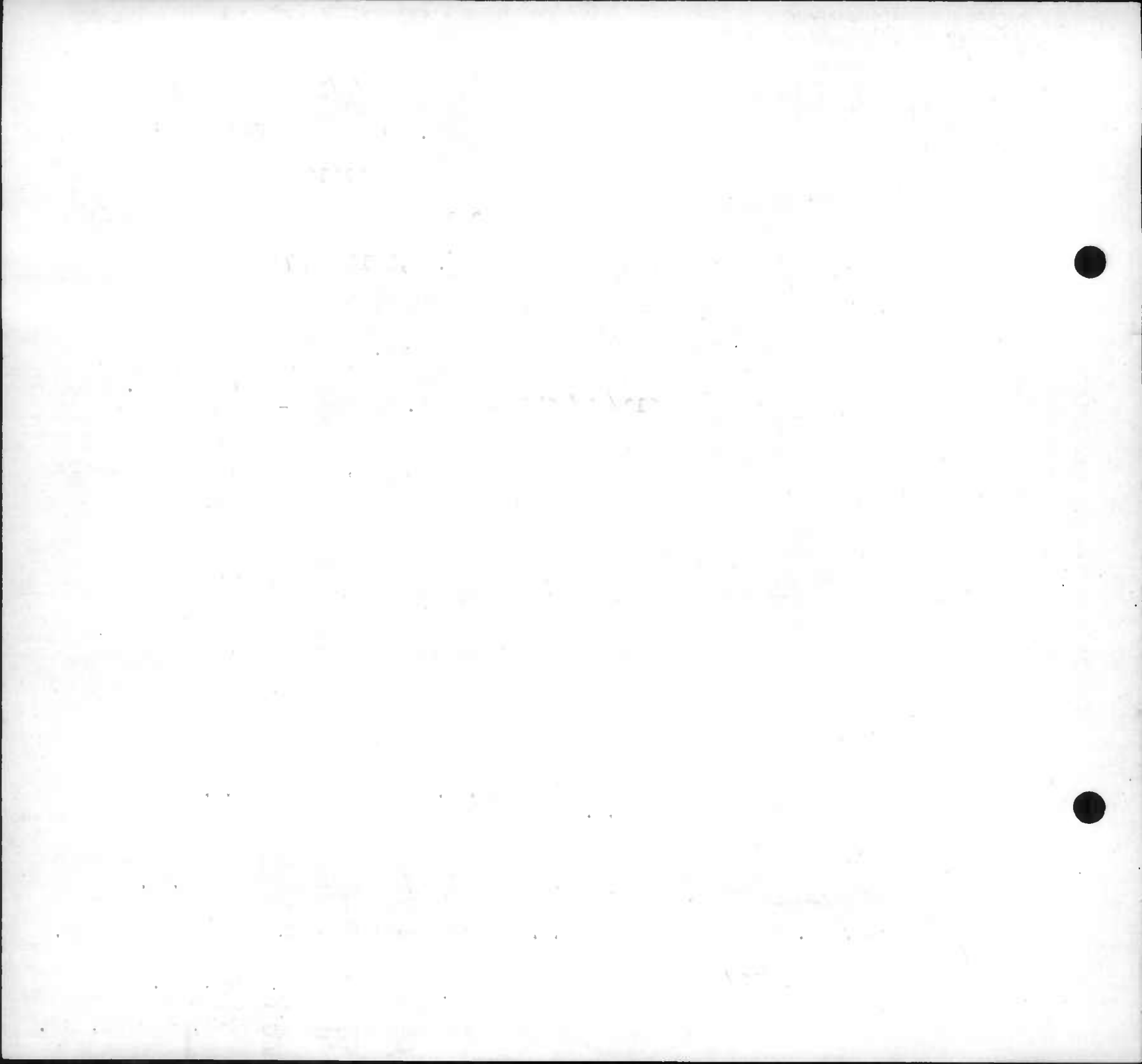
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3868

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3868

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN GETTMAN BAERWALD</b>		2. DATE AND HOUR OF DEATH <b>4/8/1968</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
				C. CITY OR TOWN <b>EDGEMERE 21219</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>3017 RITCHIE AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 4, 1911</b>	9. AGE (In years last birthday) <b>57</b>	10. Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLATE MILL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFGR</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUDOLF ERNEST BAERWALD</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213/07/7240</b>		17. INFORMANT <b>AS IN NO. 4 ABOVE</b> <b>JOHN R. BAERWALD-SON</b>			
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>1621 I</b> <b>163X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>carcinoma, right lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>	
							(B) DUE TO, OR AS A CONSEQUENCE OF:
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12.16.67</b> 19 to <b>4.8.68</b> 19, that (I) (we) last saw the deceased alive on <b>4.8.68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Eugene F. Nevy MD</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4.10.68</b>	
23C. PHYSICIAN NAME (Type) <b>Eugene F. Nevy</b>				23D. ADDRESS <b>M.D. 7001 Morningside Rd. Dundalk 21222 Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/12/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE CO. MD.</b>	
25A. DATE RECD BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <i>Walter Brooks Bradley</i>		25C. FUNERAL DIRECTOR ADDRESS <b>WALTER BROOKS BRADLEY, DUNDALK, MD.</b>			



5-650

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EDWARD SCHORN

2. DATE AND HOUR OF DEATH

APRIL 8, 1968

8:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

3408 BEL AIR ROAD BELAIR

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

6/17/85

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Tavern

10B. KIND OF BUSINESS OR INDUSTRY

Own Business

11. BIRTHPLACE (State or foreign country)

BALTIMORE  
MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

ADOLPH SCHORN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

214-34-3124A

17. INFORMANT

ADDRESS

Anna Kornder Schorn, wife, above

18.

4/12/68 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Cardiovascular

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

disease

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 4/6 to 4/8 1968,  
that (I) last saw the deceased alive on 4/8 1968 and that in (my) opinion death occurred on the date  
and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE

W. H. Schorn

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4/8/68

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/12/68

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## 68-3870 CERTIFICATE OF DEATH

REG. NO.

68-3870

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret Cornelius Janda (Janis)

2. DATE AND HOUR OF DEATH

4-8-68

8.30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31  
Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒No ☐

E. STREET AND NUMBER

2503 Jefferson Street

21205

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-24-98

9. AGE (In years  
last birthday)

69

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland-Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Cox

14. MOTHER'S MAIDEN NAME

Mary Maginore

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

219-22-1137

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

796.9 I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

NOT KNOWN R/O  
Hypothyroidism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

795.5 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-4-1968 to 4-8-1968,  
that (I) (we) last saw the deceased alive on 4-8-1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Dowd J. Yarborough

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-8-68

23C. PHYSICIAN'S  
NAME (Type)

Dowd J. Yarborough

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/11/68

24C. NAME of CEMETERY or CREMATORY

Bohemian National Cem.

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

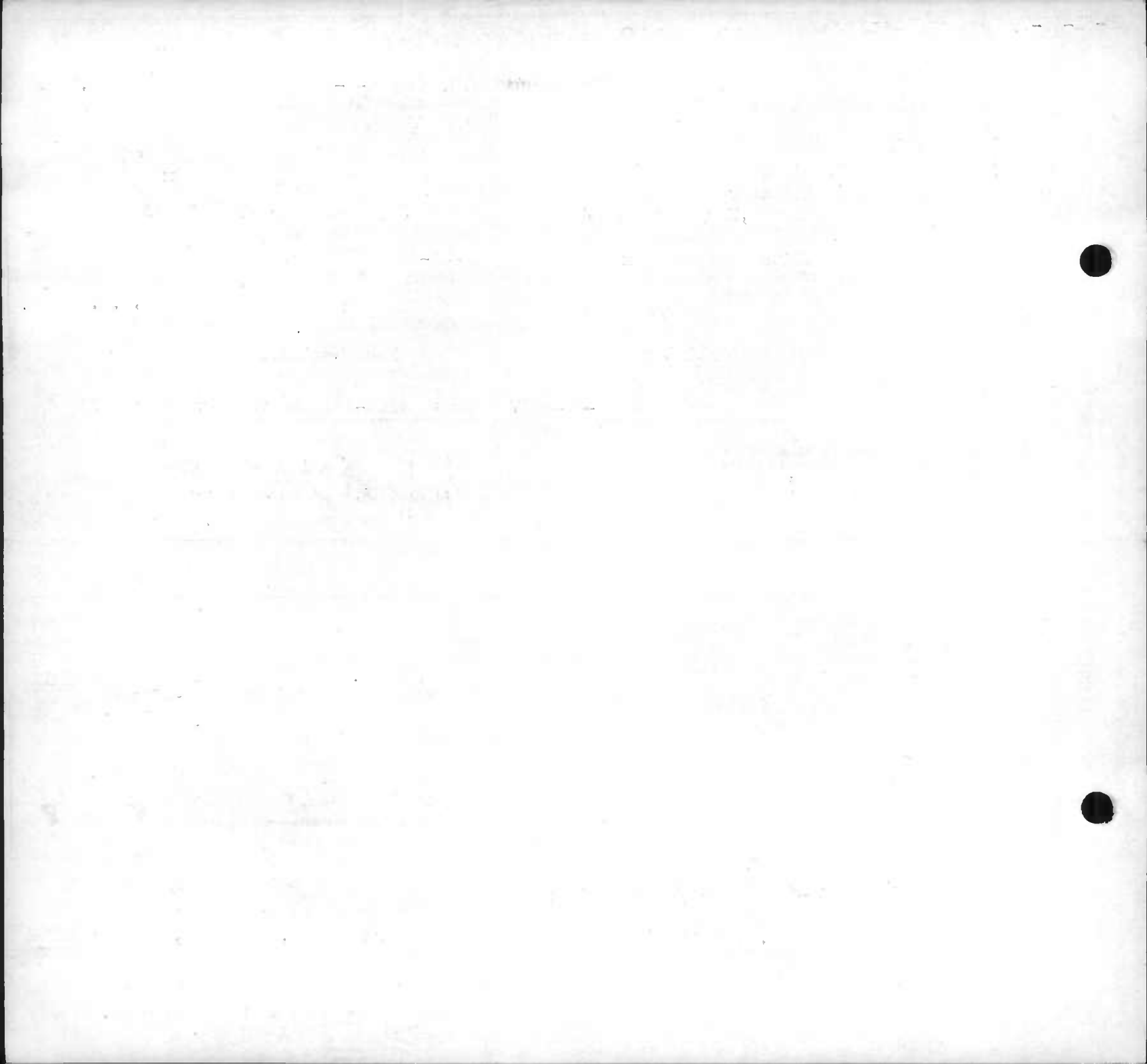
25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
2601 E. Madison St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3871

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3871

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EMILY SAMPIAS</b>		2. DATE AND HOUR OF DEATH <b>April 8, 1968</b>   <b>1</b> a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> CITY OF <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2443 JEFFERSON STREET</b> <b>21205</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-87</b>	9. AGE (In years last birthday) <b>80 yr. old</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>CZECHOSLOVAKIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN FABRY</b>		14. MOTHER'S MAIDEN NAME <b>MARIA DELLAVOSA CHUDOWSKI</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. —	17. INFORMANT ADDRESS <b>MR. JOHN SAMPIAS 2443 JEFFERSON ST.</b>		
18. <b>4/10/68</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Prob. Myocardial Infarction</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Ca. 1 hr</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic C=V disease</b>		<b>10 years.</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March, 31, 1968</b> to <b>April 8, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 7, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David J. Shaw, MD</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>April 8, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAVID J. SHAW, M.D.</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/11/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>BOHEMIAN NAT'L Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>		25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZIROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	

10-7-80

Geoffrey Leitch

10-7-80

Mr. John Leitch

W

T

How much

24

David Johnson MD

James L. Leitch

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3872

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA T. BOCHNIAK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 8, 1968 7:00 A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2426 Fleet Street		3. DATE PRONOUNCED DEAD Month Day Year April 8, 1968 7:00 A M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH MAY 9, 1913		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 54		E. STREET AND NUMBER 2426 Fleet Street	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STANISLAUS ZYSK		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOOD PROCESSING	
15. MOTHER'S MAIDEN NAME FRANCES KALATA		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218-07-7359		18. INFORMANT MR. ROMAN BOCHNIAK	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4-12-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4-8-68		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 4-10-1968		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. APR 11 1968	
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Raymond L. Kaczorowski	
25D. ADDRESS FLEET ST.		25E. ADDRESS 2525	

MAY 1913 - 24

MARYLAND W. S. A. Stanistaus 172K

Food Processing Airway Colo Frances Kalata

218-07-100000 Roman Bochnik 24-07-100000

NO

Gen. M. K.

General 4-10-1913 Holm Rosen Gerten Baltimore

Raymond A. Kaczmarek

R-155 1

68- 3873

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3873

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HYMAN RIFMAN

2. DATE AND HOUR OF DEATH

APRIL 8, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

98601 PALL MALL RD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

BALTO

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4601 PALL MALL RD

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4/5/1962

9. AGE (In years  
last birthday)

86

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

RUSSIA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Israel

14. MOTHER'S MAIDEN NAME

Rifka

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

22044-0844

17. INFORMANT

AURUM RIFMAN 3412 WALBASH AVE

ADDRESS

18. 4/12/9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute Pulmonary Edema

2 hrs.

(B) DUE TO, OR AS A CONSEQUENCE OF:

myocardial infarction

3 weeks

(C) DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis - C. V. S.

10 yrs.

MEDICAL CERTIFICATION

422.1 II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-13 - 1965 to 4-8 - 1968,  
that (I) (we) last saw the deceased alive on 4-7 - 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. A. Silverman M.D.

DEGREE

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

4-9-68

23C. PHYSICIAN'S  
NAME (Type)

A. A. SILVERMAN

DEGREE

23D. ADDRESS

6210 PARK HEIGHTS AVE, Baltimore

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/9/1968

24C. NAME OF CEMETERY or CREMATORY

Anshe Emenah City Chain Balto

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

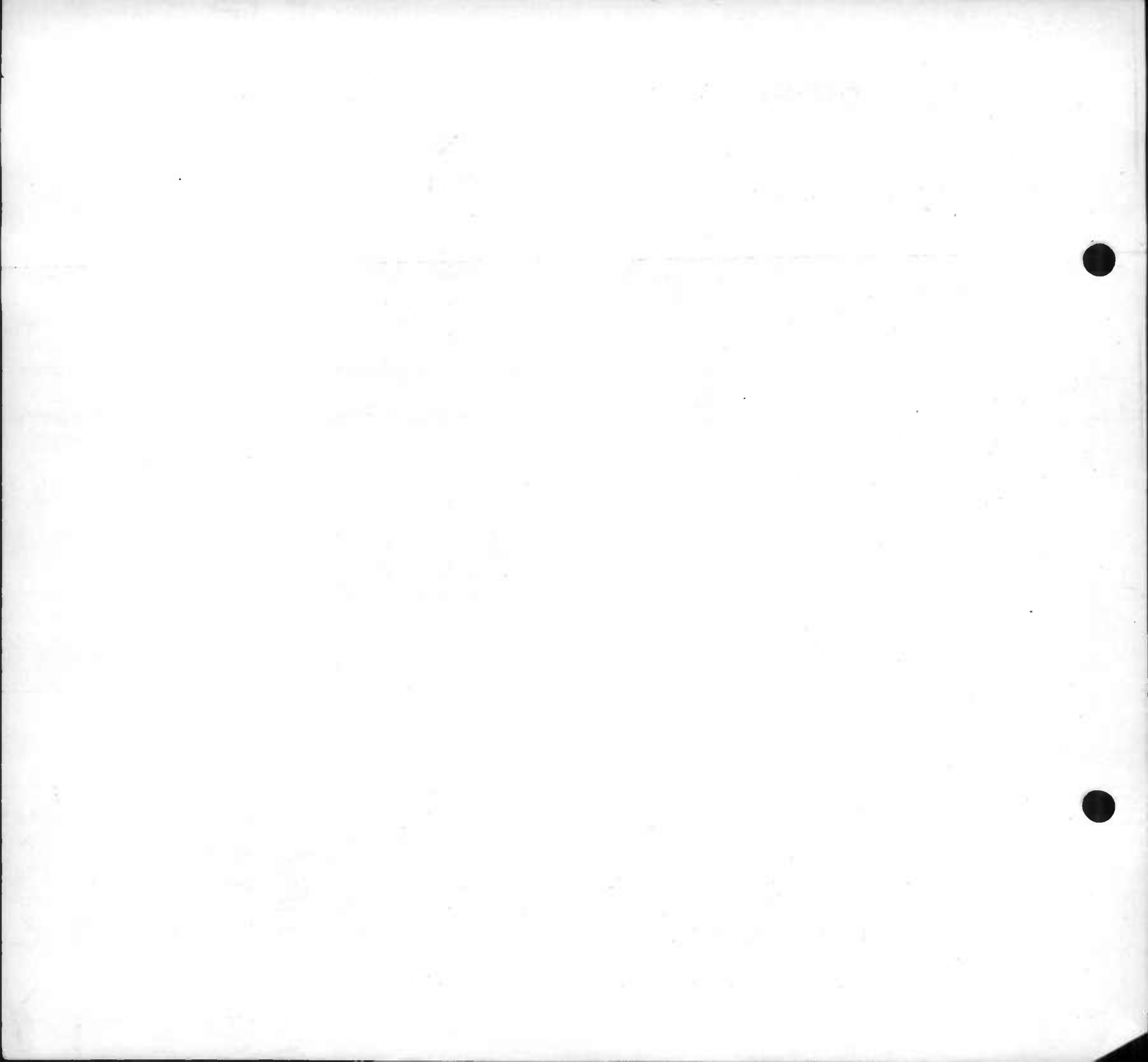
Sydney S. Lewis &amp; Son, INC

ADDRESS

Garrison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
m-250

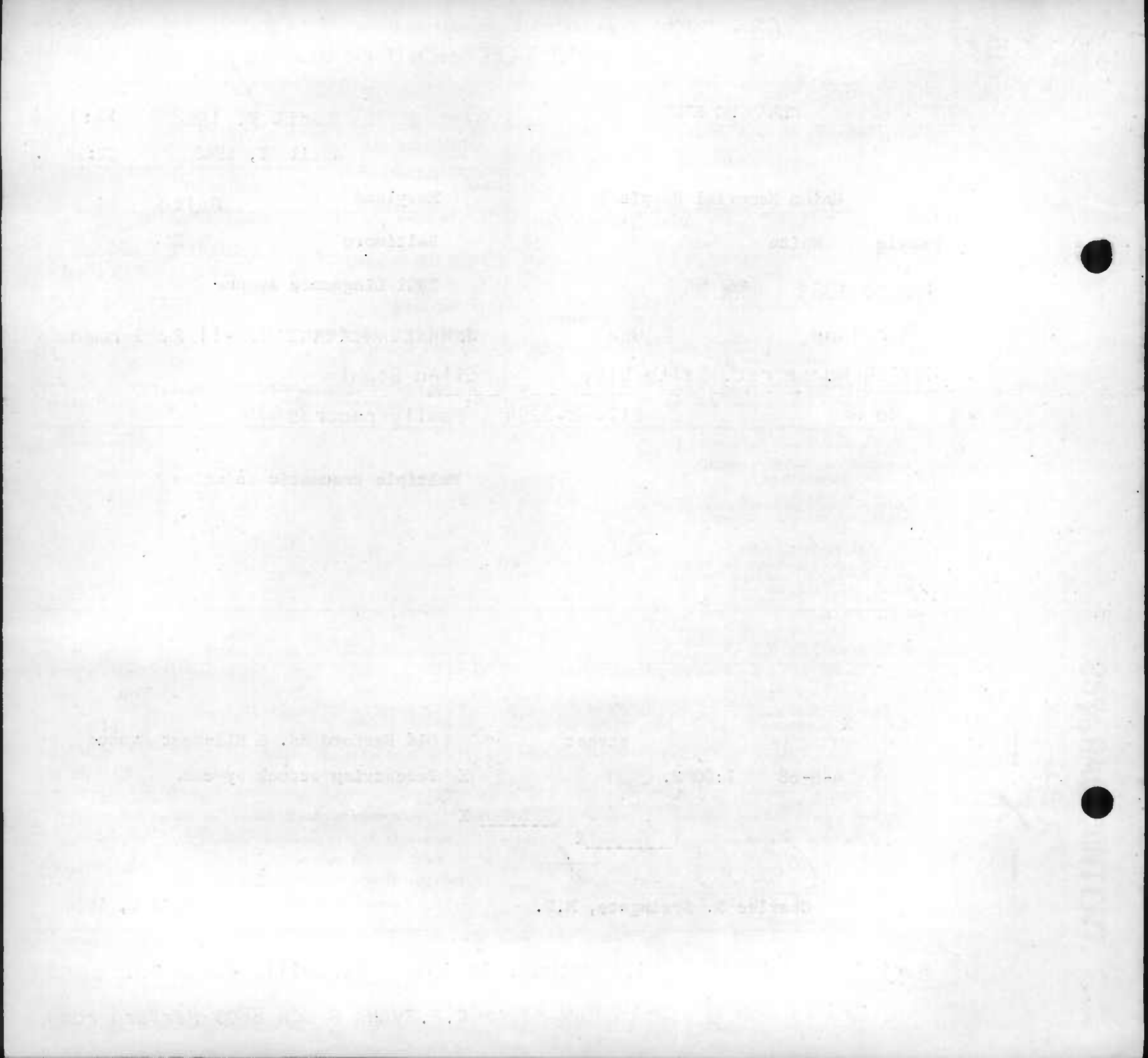
68- 3874 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3874

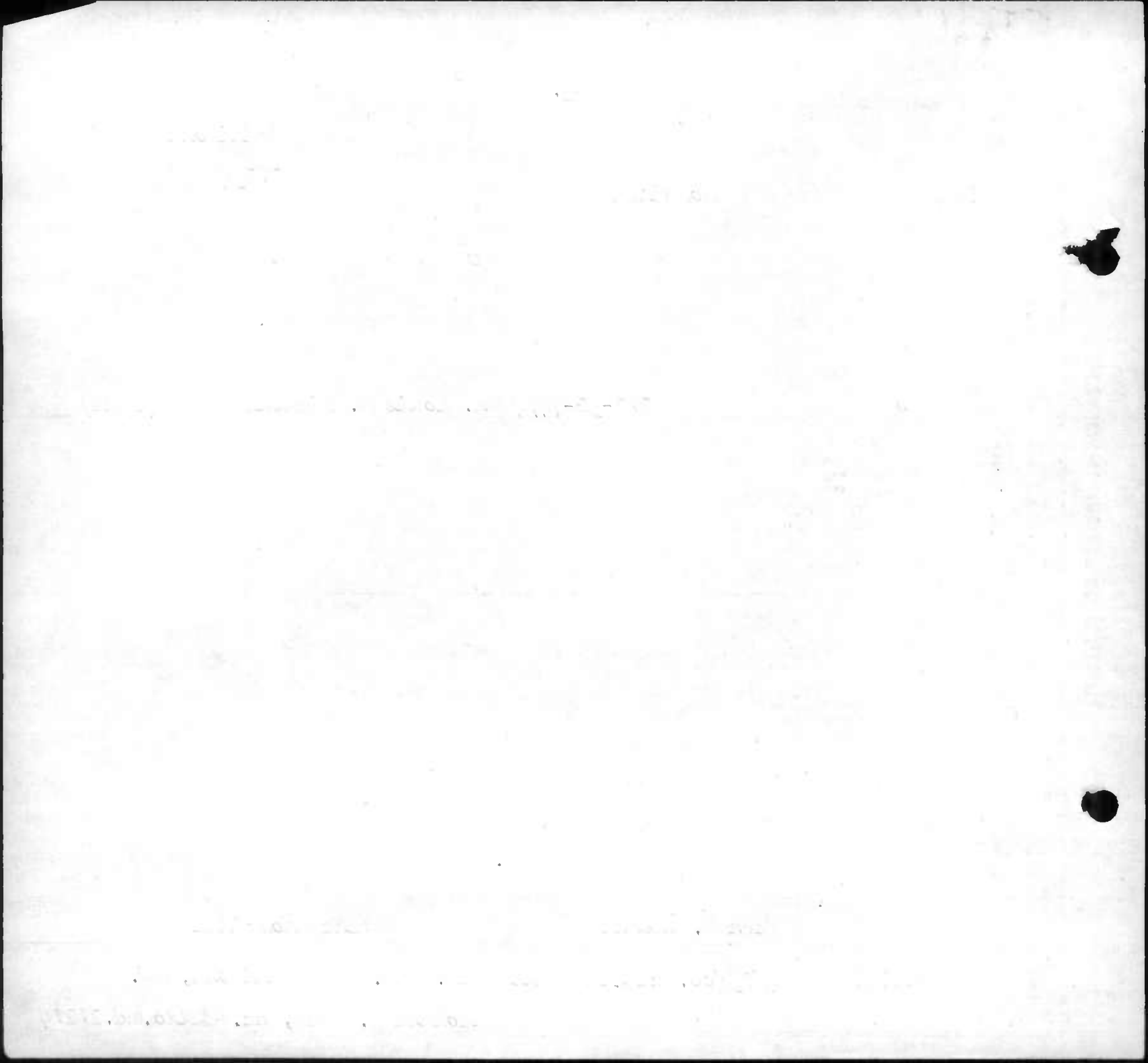
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 7, 1968 12:30 AM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		3. DATE PRONOUNCED DEAD April 7, 1968 12:30 AM		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb 20 1883		10. AGE (In years last birthday) 85	11. BIRTHPLACE (State or foreign country) Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME XXXXXXXXXXXXX Howell P. German		E. STREET AND NUMBER 2801 Linganore Avenue	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Nurse ret. Balto City		15. MOTHER'S MAIDEN NAME Ellen Stahl		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 217-48-0254		18. INFORMANT Family records		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Old Harford Rd. & Hilcrest Avenue	
22D. TIME OF INJURY (APPROX.) 4-6-68 7:00 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type) DATE SIGNED: April 7, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/68		24C. NAME of CEMETERY or CREMATORY Hiss Method. Ch Fem	
24D. LOCATION (City, town, or county) (State) Parkville Balto Md.		25A. DATE REC'D BY HEALTH DEPT. APR 11 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR C.F. EVANS & SON		25D. ADDRESS 8802 Harford road			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">68-3875</span>	
68-3875				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Simmons, Bridget C.</i>	
2. DATE AND HOUR OF DEATH <i>4-10-68 12:25 A.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MERCY Hospital</i>			
5. SEX <i>F</i>		6. RACE <i>Caucasian</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	
8. DATE OF BIRTH <i>6-20-10</i>		9. AGE (In years last birthday) <i>57</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	
11. BIRTHPLACE (State or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Patrick Lee</i>	
14. MOTHER'S MAIDEN NAME <i>Ellen Mc Helis</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-32-9474</i>	
17. INFORMANT <i>Mr. Louis R. Simmons</i>		ADDRESS <i>(Same)</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>199.2 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> 19 <i>68</i> to <i>4-10</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>4-9</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jean M. Thorne</i> M.D.				23B. DATE SIGNED <i>4-10-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jean M. Thorne</i> M.D.				23D. ADDRESS <i>Mercy Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/15/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Mem. Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>			
25B. NAME OF REGISTRAR <i>Q. E. E. Talley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			



W-420

68-3876

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-3876

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>THOMAS P. WALLACE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>April 5, 1968</b> <b>UNK</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00644 E. 27th Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 9, 1968</b> <b>2:20 P.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Aug. 15, 1924</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postal Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>		17. SOCIAL SECURITY NO. <b>219-12-9098</b>	
13. FATHER'S NAME <b>Patrick Wallace</b>		15. MOTHER'S MAIDEN NAME <b>Nellie O'Connor</b>	
18. INFORMANT <b>Mr. Francis Wallace</b>		ADDRESS <b>2212 Cloville Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of Liver</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>5-8-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
21. AUTOPSY? (Yes or No) <b>Yes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/10/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/13/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

68- 3877

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3877

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Steven Barry Kahn

2. DATE AND HOUR OF DEATH

April 7, 1 968

3:25 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

US Public Health Service Hospital  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE 8. COUNTY

Md.

C. CITY OR TOWN

Silver Spring

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

12414 Eastbourne Drive

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10/15/55

9. AGE (In years  
last birthday)

12

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mich.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Bernard Kahn

14. MOTHER'S MAIDEN NAME

Pauline Miller

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md

18.

191X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Pontine glioma

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

193.0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

no

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
Work

Not While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 3 19 68 to Apr. 7 19 68  
that (I) (we) last saw the deceased alive on Apr. 7 19 68 and that in (I) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry S. Crist, M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

4/8/68

23C. PHYSICIAN'S  
NAME (Type)

Henry S. Crist, SA Surg (R)

23D. ADDRESS

US PHS Hospital, Balto, Md. 21211

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Apr. 9, 1968

24C. NAME OF CEMETERY OR CREMATORY

King David Memorial Garden

24D. LOCATION

Falls Church,

(City, town, or county) (State)

Virginia

25A. DATE RECEIVED BY HEALTH DEPT

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Sisk

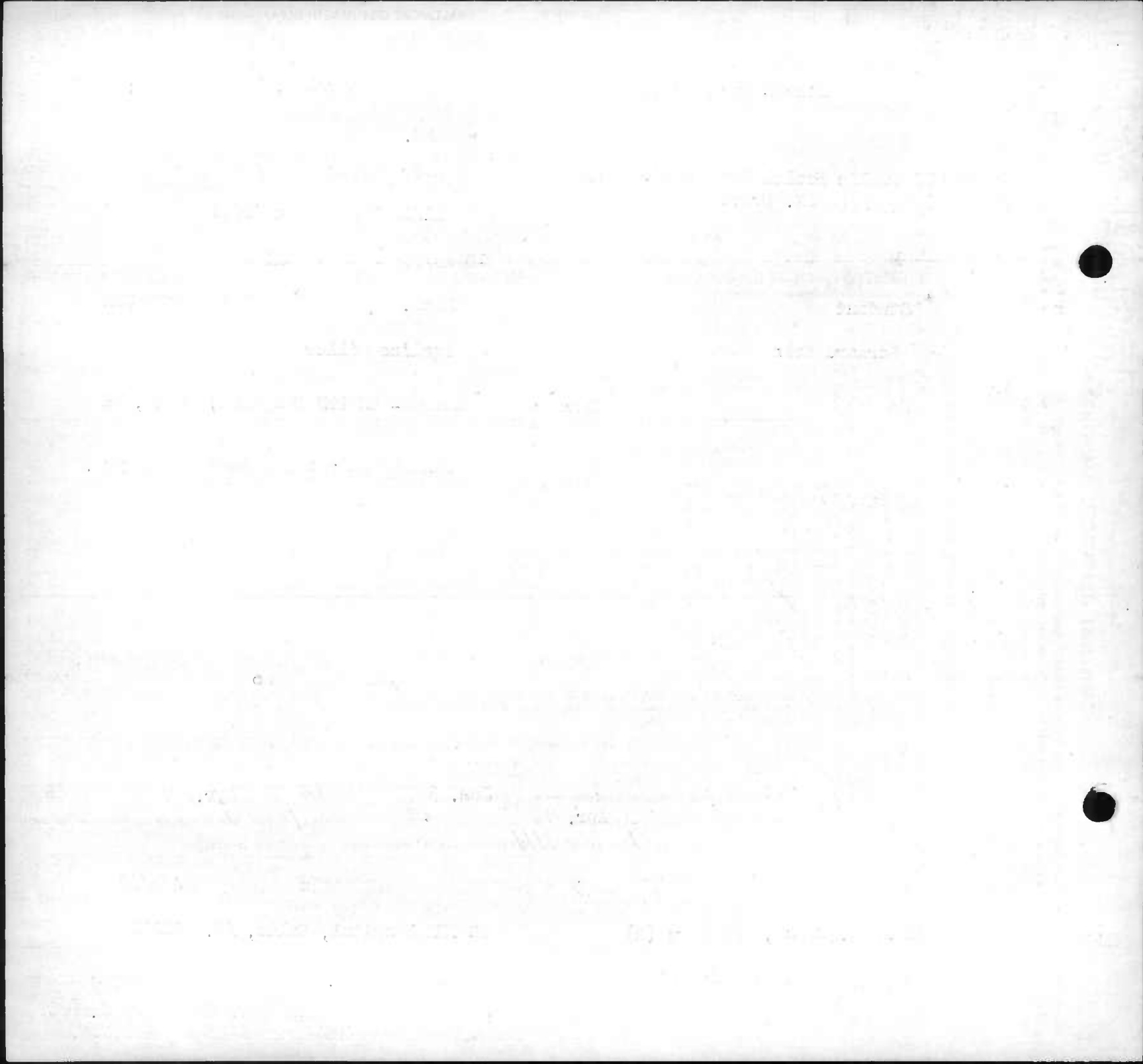
25C. FUNERAL DIRECTOR

Donald M. Stein 232 Carroll

ADDRESS

Hebrew Memorial Funeral Home St., N.W.

Wash., D. C.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68- 3878 CERTIFICATE OF DEATH					REG. NO. 68- 3878				
1. NAME OF DECEASED (Type or Print) <i>Paul Davis</i>					2. DATE AND HOUR OF DEATH <i>April 8 - 1968 1P.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>2309 Roslyn Ave</i>					C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER <i>18-02</i>				
5. SEX <i>Male</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-1900</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore City Md</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Murray Davis</i>			14. MOTHER'S MAIDEN NAME <i>Laura</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>212-12-5918</i>		17. INFORMANT <i>Allen Thomas</i>		ADDRESS <i>343 Robert St</i>		
18. <i>412.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Arteriosclerotic Cardiovascular Disease</i> (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>422.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Vascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>January 1968</i> to <i>April 8 1968</i> , that (I) (we) last saw the deceased alive on <i>April 5 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Louis T. Lavy</i>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>April 10 - 1968</i>		
23C. PHYSICIAN'S NAME (Type) <i>LOUIS T. LAVY M.D.</i>					23D. ADDRESS <i>3502 W. Rogers Ave</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>4-12-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>			25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>			25C. FUNERAL DIRECTOR <i>Frances A. Hensley</i>		ADDRESS <i>378 W Biddle St</i>	



T-520

68- 3879 BALTIMORE CITY HEALTH DEPARTMENT

68- 3879

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GRADY B. TOMES</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 28, 1968 10:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour March 28, 1968 10:55 A.M.	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (in years lost birthday) <b>44</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS	

MEDICAL CERTIFICATION	19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	20. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
	20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

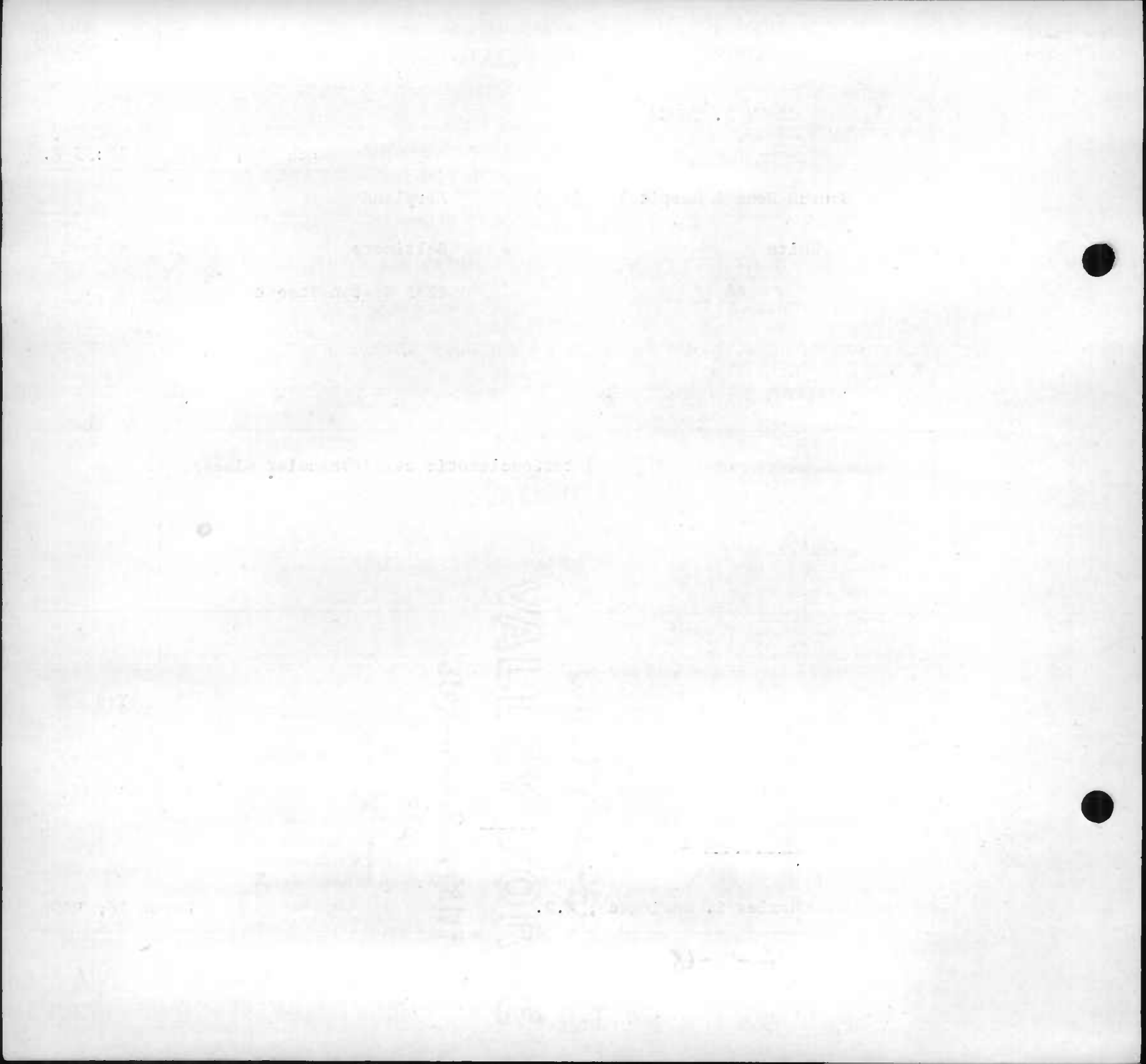
ACTUAL SIGNATURE *Charles S. Springate* M.D.  
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **March 28, 1968**

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>4-11-68</b>	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>	25B. NAME OF REGISTRAR <i>John E. Faldut</i>	25C. FUNERAL DIRECTOR	ADDRESS

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
68-05715 68- 3880 CERTIFICATE OF DEATH									
BIRTH NO. <u>68-05715 68- 3880</u>					REG. NO. <u>68- 3880</u>				
1. NAME OF DECEASED (Type or Print) <u>Baby Girl JACKSON</u>					2. DATE AND HOUR OF DEATH <u>4-1-68</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL</u> <u>Baltimore MARYLAND</u>					C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <u>4214 FAIRFAX ROAD</u>									
5. SEX <u>Fe ?</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-68</u>		9. AGE (In years last birthday) <u>28-03</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>John R. Jackson</u>					14. MOTHER'S MAIDEN NAME <u>Gaynell Gaddy</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>chart</u>		
18. <u>770.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>abruptio Placenta</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>4-1-68</u>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> 19 <u>68</u> to <u>4-1</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Louis L Randall MD</u>					23B. DATE SIGNED <u>4-1-68</u>				
23C. PHYSICIAN'S NAME (Type) <u>Louis L Randall MD</u>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>4-10-68</u>					24B. DATE				
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
25C. FUNERAL DIRECTOR					ADDRESS				

cc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3881

REG. NO.

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT COOKE KOCH

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

3

27

68

7:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

University Hospital D.O.A.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

March

27

1968

7:45 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

512 Callender St.

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gastro-intestinal bleeding  
DUE TO, OR AS A CONSEQUENCE OF:

duodenal ulcer

(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CAUSATION LAST.

Lung cancer with metastasis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A.

EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING  
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

22D.

TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 27, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

4-11-68

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 11 1968

Robert E. Farber

ANATOMY BOARD  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

Letter from M.E. Office 5-27-68 M.H.

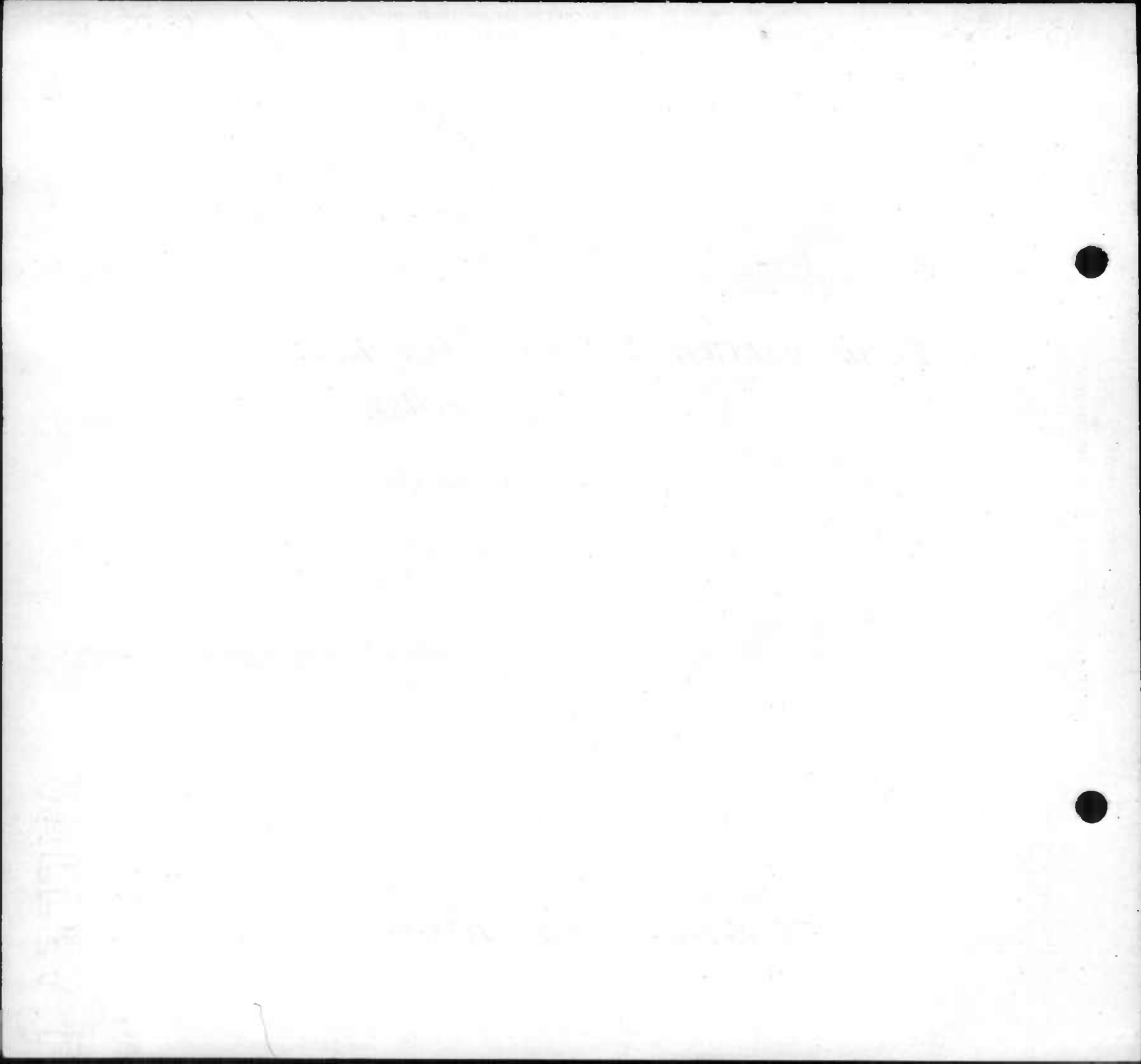
CERTIFICATE

244910K

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">68-3882</span> <span style="float: right;">4</span>
BIRTH NO. <span style="font-size: 1.2em;">68-06367 68-3882</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BABY BOY BARNES</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4/6/68 10:30 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">LUTHERAN HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">21146</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Severna Park</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">Rt # 1 Box 453</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4/6/68</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">1</span> 10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <span style="font-size: 1.2em;">IRVIN CLAYTON BARNES</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY NELL JONES</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">mother</span>
18. <span style="font-size: 1.2em;">777X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">IMMATURITY</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <span style="font-size: 1.2em;">776X II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/6/68</span> 19 to <span style="font-size: 1.2em;">4/6/68</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/6/68</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">F. S. Peroma</span> DEGREE				23B. DATE SIGNED <span style="font-size: 1.2em;">4/6/68</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">F. S. Peroma M.D.</span> DEGREE				23D. ADDRESS <span style="font-size: 1.2em;">LUTHERAN HOSPITAL OF BALTIMORE</span>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.2em;">4-11-68</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 11 1968</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jenkins</span>		25C. FUNERAL DIRECTOR ADDRESS



R-152

68-3883

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3883

## BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD ROBINSON

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month Day Year

4 8 68

Hour

10:31 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

002nd St. Brooklyn D.O.A.

3. DATE  
PRONOUNCED DEAD

Month Day Year

April 8, 1968

Hour

10:31 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12/13/56

10. AGE (In years  
last birthday)

11 yrs.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3431 Chessell Ct.

11. BIRTHPLACE (State or foreign country)

BALTO. Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

SILAS DUNWITH

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CHILD

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

OLA MAE ROBINSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

OLA MAE ROBINSON 3431 Chessell Ct

19.

E91019

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Drowning  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Partial

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Harbor

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Harbor foot of 2nd St. 25-06

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

4 7 68 4:00p

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject fell overboard

23.

I certify that I held on Inquiry ☐ Inspection ☐ P Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 9, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4/12/68

24C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

24D. LOCATION (City, town, or county) (State)

A. A. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 11 1968

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Joseph B. Locks, Jr. 1304 N. Central Ave.

1000

WALT

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-200		68- 3884		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68- 3884	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Pearl A. Keiss</u>				2. DATE AND HOUR OF DEATH <u>4/9/68</u> <u>11 58</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>2926 Silver Hill Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/98</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Waddell</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Stotler</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219 44 5255</u>		17. INFORMANT <u>Leonard Keiss-2926 Silver Hill Avenue # 7</u>				ADDRESS	
18. <u>153331</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Recurrent Adeno Carcinoma</u> <u>259 mm, c pelvic extension</u> <u>Cardiac arrest</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Ca colon</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. <u>15333 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>25/23/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca sigmoid colon</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3/27 1968</u> to <u>4/9 1968</u> , that (I) (we) last saw the deceased alive on <u>4/9 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>William A. Seovill M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/9/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>William A. Seovill M.D.</u>				23D. ADDRESS <u>Maryland General Hto.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-13-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hgts.</u>			

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68- 3885

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3885

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NAPOLEON SLAY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 9:20 P.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-47</b>		6. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-2-1933</b>	10. AGE (In years lost birthday) <b>35</b>	11. BIRTHPLACE (State or foreign country) <b>ALA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHNNIE THOMPSON</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		15. MOTHER'S MAIDEN NAME <b>LULA SLAY</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-18-3628</b>	
18. INFORMANT <b>LULA SLAY</b>		ADDRESS <b>2115 Koko LA.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E9651X</b>		CAUSE OF DEATH <b>Gunshot wound of left eye with perforation of brain</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Harford Avenue &amp; La Fayette Street</b>	
22D. TIME OF INJURY (APPROX.) <b>4-6-68 9:00 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED <b>April 7, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-10-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. COUNTY MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>	
		25C. FUNERAL DIRECTOR <b>JOSEPH KNIGHT 1639 N. Broadway</b>	

VALIDITY

W. 426

68- 3886

BALTIMORE CITY HEALTH DEPARTMENT

68- 3886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>SAMUEL M. WALKER, Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>April 9, 1968</b> 5:30 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Police Boat SAN SMITH PARK</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 9, 1968</b> 5:30 A.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>20-01</b>	
9. DATE OF BIRTH <b>7/4/1896</b>		10. AGE (In years lost birthday) <b>71</b>	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO. <b>213-07-986</b>	
18. INFORMANT <b>Grace Walker</b>		ADDRESS <b>1812 W. Lexington St</b>	
19. <b>E 910.19</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Drowning</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>water HARBOR</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>UNK HARBOR SAN SMITH PARK</b>		22F. HOW DID INJURY OCCUR? <b>UNK Found DROWNED 22-01</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>UNK UNK</b>		22E. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-12-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St</b>	

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68- 3887

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3887

BIRTH NO. 68-5495

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLOTTE ARMSTRONG</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 9(25) A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3/26/68</b>		10. AGE (In years last birthday) <b>11</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		15. MOTHER'S MAIDEN NAME <b>Georgia Wells</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>James Armstrong</b>		ADDRESS <b>2502 E. Eager St.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Sudden death in infancy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): <b>795-2</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/9/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Sisk</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

3/25/66

Weyland

Child

James Armstrong

U.S.A.

Georgia Wells

James Armstrong 1908 A. 1907 A.

James Armstrong 1908 A. 1907 A.

California, Weyland

Weyland

3/25/66

Child

Charles A. Wells 1908 A. 1907 A.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HOWARD

JOHNSON

2. DATE  
OF  
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☒

April 8, 1968

11:00 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

828 Plum Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

April 8, 1968

1:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

22-02

6. SEX

male

7. RACE

negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (in years  
lost birthday)

68

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

ALLEY

828 Plum Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

213-70-7821A

18. INFORMANT

ADDRESS

Elizabeth Shannon 2626 Lanthana

19. 412.01

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Arteriosclerotic and Hypertensive Cardio-  
(A) IMMEDIATE CAUSE  
~~Arteriosclerotic and Hypertensive Cardio-~~  
vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/9/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 11 1968

Robert E. Farkas, M.D.

Charles R. Price 6614 W. Barry

Continued on

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3889	
BIRTH NO. 68- 3889					
1. NAME OF DECEASED (Type or Print) CHARLES ANDERSON			2. DATE AND HOUR OF DEATH 10 APRIL 1968 3:53 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-12		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN A VENUE BALTIMORE, MARYLAND #21224			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1-21-81		9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN			10B. KIND OF BUSINESS OR INDUSTRY MERCHANT MARINE		11. BIRTHPLACE (State or foreign country) SWEDEN
13. FATHER'S NAME AUGUST ANDERSON			14. MOTHER'S MAIDEN NAME SOPHIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 212-16-4325 A		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY ARREST (B) GRAM NEG PNEUMONITIS (C) ASCUD w CHF		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 14 OCTOBER 1966 to 10 APRIL 1968, that (I) (we) last saw the deceased alive on 10 APRIL 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did), (did not) view the body after death.					
23A. SIGNATURE Melvyn S. Tockman			23B. DATE SIGNED 4-10-68		23C. PHYSICIAN'S NAME (Type) MELVYN S. TOCKMAN, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/13/68		24C. NAME OF CEMETERY Sacred Heart of Jesus
24D. LOCATION (City, town, or county) Balto. Co., Md.			25A. DATE REC'D BY HEALTH DEPT. APR 11 1968		
25B. NAME OF REGISTRAR Robert E. Isakson			25C. FUNERAL DIRECTOR Wm. Fialkowski		
25D. ADDRESS 2007 Eastern Ave.			25E. ADDRESS		

MERCHANT MARINE

DEMAN

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10/10/18

10/10/18

10/10/18

10/10/18

10/10/18

Received 4/10/18 from Merchant Marine

for 10/10/18

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>D-5525</b></span> <span><b>68-3890</b></span> </div> <div style="text-align: center;"> <b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b> </div>		REG. NO. _____ <div style="text-align: right;"> <b>68-3890</b> </div>	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>DENSMORE MR RALPH S.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>35 CHURCH HOME AND HOSPITAL</b>		2. DATE AND HOUR OF DEATH <b>4-9-68 6-45 P.M.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME AND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____ C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-9-99</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TRAINMASTER</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES DENSMORE</b>		14. MOTHER'S MAIDEN NAME <b>LUCY PROGAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-09-1670</b>	
17. INFORMANT <b>WIFE</b>		ADDRESS <b>315 NORTH BEND RD.</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of lung, Probable</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Central + hepatic metastases</b>	
19. DATE OF OPERATION <b>163X II</b>		20. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Church Home + Hospital</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>100 N Broadway, Baltimore</b>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>4-7-68</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>4-7-68</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4-7-68</b> to <b>4-9-68</b> , that (I) (we) last saw the deceased alive on <b>4-9-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Francisco Baltazar</b>		23B. DATE SIGNED <b>4/9/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCISCO BALTAZAR, MD</b>		23D. ADDRESS <b>Church Home + Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-13-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>LORRAINE PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	
25C. FUNERAL DIRECTOR <b>WEBER FUNERAL HOME</b>		ADDRESS <b>5311 EDMONDSON AVE</b>	

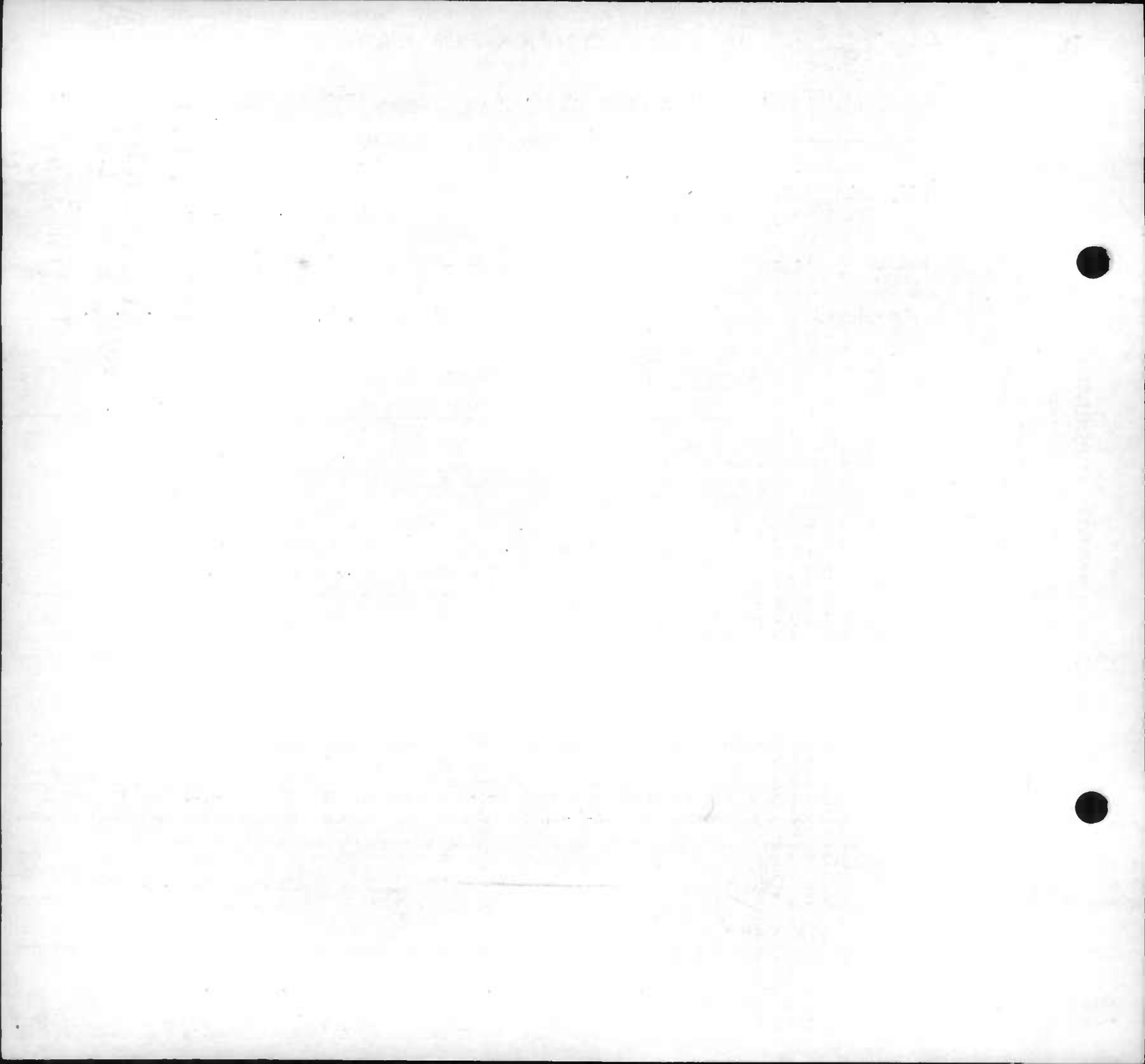
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-3891	
D-620 68-3891		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Dorsey, Carrie (Caroline V.)		4-7-68 3:15 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland		Maryland			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		15-01			
1319 Whatcoat Street					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-2-85	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed				Washington D. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Butler		Mary Lee		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Harry Davis 1404 Laurens St.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cerebrovascular Accident			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arterio Sclerosis			
		(C) Senility and Negligence			
331X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-5-68 19 to 4-7-68 19, that (I) (we) last saw the deceased alive on 4-7-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature] DEGREE				4-8-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR KHAN					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)	
Burial	4-11-68	Mt. Auburn Cem.	Balto.	Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
APR 11 1968		R. E. [Signature]	Kelson Funeral Home 1348 Calhoun St.		



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3892

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELLIS Ray PEOPLES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3590 Dolfield Avenue (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968 1:10 P.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-16-44</b>		10. AGE (In years lost birthday) <b>24</b>	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Iseline Page</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>237627430</b>		18. INFORMANT ADDRESS <b>Lorraine Capers 4012 Annellen Rd.</b>	
19. <b>571.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty Alteration of Liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>5-21-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Partial</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>4/9/68</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-12-68</b>	
24C. NAME of CEMETERY or CREMATORY <b>Church Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Greenville, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Wilson General Home</b>		ADDRESS <b>1348 Calhoun St.</b>	

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3893

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68-3893

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ira B. Vaughan		4-5-68 9 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY					
Maryland					
C. CITY OR TOWN D. INSIDE CITY LIMITS					
Baltimore YES 710 NO					
E. STREET AND NUMBER					
5303 Kenilworth ave					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Colored	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-9-31	36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Social Security					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Masley			Bessie Norris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			213-30-8439		Phillips Vaughan Same
18. 1750 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
CANCER OF OVARY					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
1750 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
				9 AM	
22. I certify that (I) (this hospital) attended the deceased from 4-1-1968 to 4-5-1968, that (I) (we) last saw the deceased alive on 4-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jerome Gaher				4-5-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JEROME GAHER				5706 BELLONA AV	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-9-68		Baltimore National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 11 1968		L. E. Jenkins		Baltimore Phillips 5727 N. Main St.	

4th May 1942

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THE DECEASED

James John  
TERRACE OFFICE

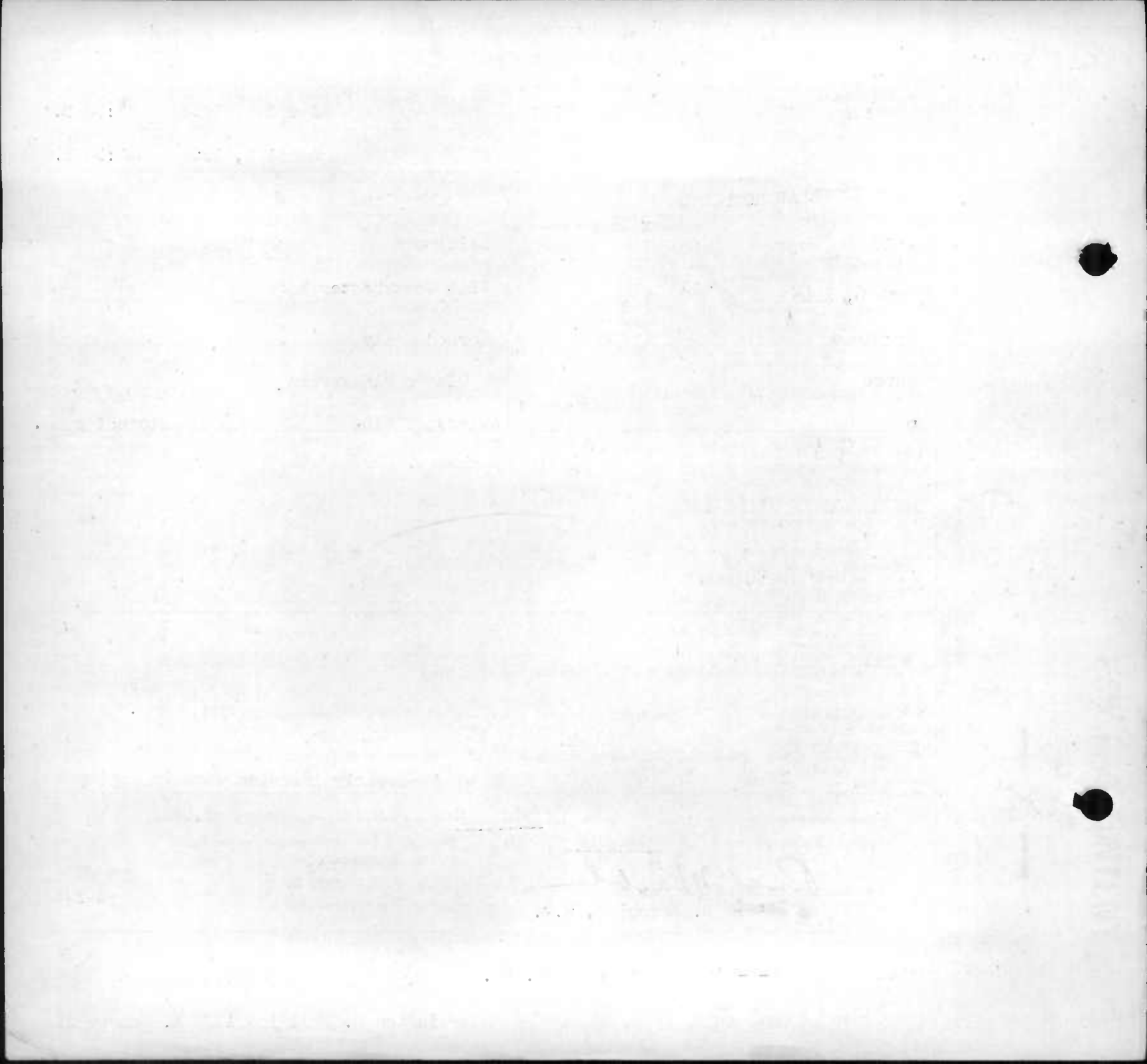
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3894

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>EVA KING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 2, 1968</b>		Hour <b>2:30 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 2, 1968</b>		Hour <b>2:30 P.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>4506 Westchester Road</b>
9. DATE OF BIRTH <b>March 6, 1945</b>		10. AGE (In years last birthday) <b>23</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Vernon Holly</b>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		14B. KIND OF BUSINESS OR INDUSTRY		
15. MOTHER'S MAIDEN NAME <b>Gladys Eleckerson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Sylvester King</b>		
19. <b>642.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Septic Abortion</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>651.2 II</b>				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unk.</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unk.</b>
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>3 29 68 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Apparently inserted wire in vagina</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> EXAMINER'S NAME (Type)		M.D. <b>Ronald N. Kornblum, M.D.</b>		DATE SIGNED <b>4-3-68</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-68</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Folsom</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Arlington S. Phillips 1727 N. Monroe St</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3895 CERTIFICATE OF DEATH

REG. NO.

68- 3895

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Samuel Smith

2. DATE AND HOUR OF DEATH

4-6-68

12 35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital  
BALT. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1058 Argyle Ave.

5. SEX

M

6. RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6-1-1896

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Edgewood Arsenal

11. BIRTHPLACE (State or foreign country)

LA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mobley Smith

14. MOTHER'S MAIDEN NAME

Emma (MN) Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

W W I

16. SOCIAL  
SECURITY NO.

21503-1782

17. INFORMANT

(Mrs.) Lillian Smith 1058 Argyle St.

ADDRESS

18. ~~185 X~~ I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CANCER OF PROSTATE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

19. DATE OF OPERATION  
20. SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

II  
Arteriosclerotic cardiovascular dis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, form, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-5 1968 to 4-6 1968,  
that (I) (we) last saw the deceased alive on 4-5 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Insoft M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

4-6-68

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-10-68

24C. NAME OF CEMETERY OR CREMATORY

carver Mem. Park

24D. LOCATION

(City, town, or county)

Laurel, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

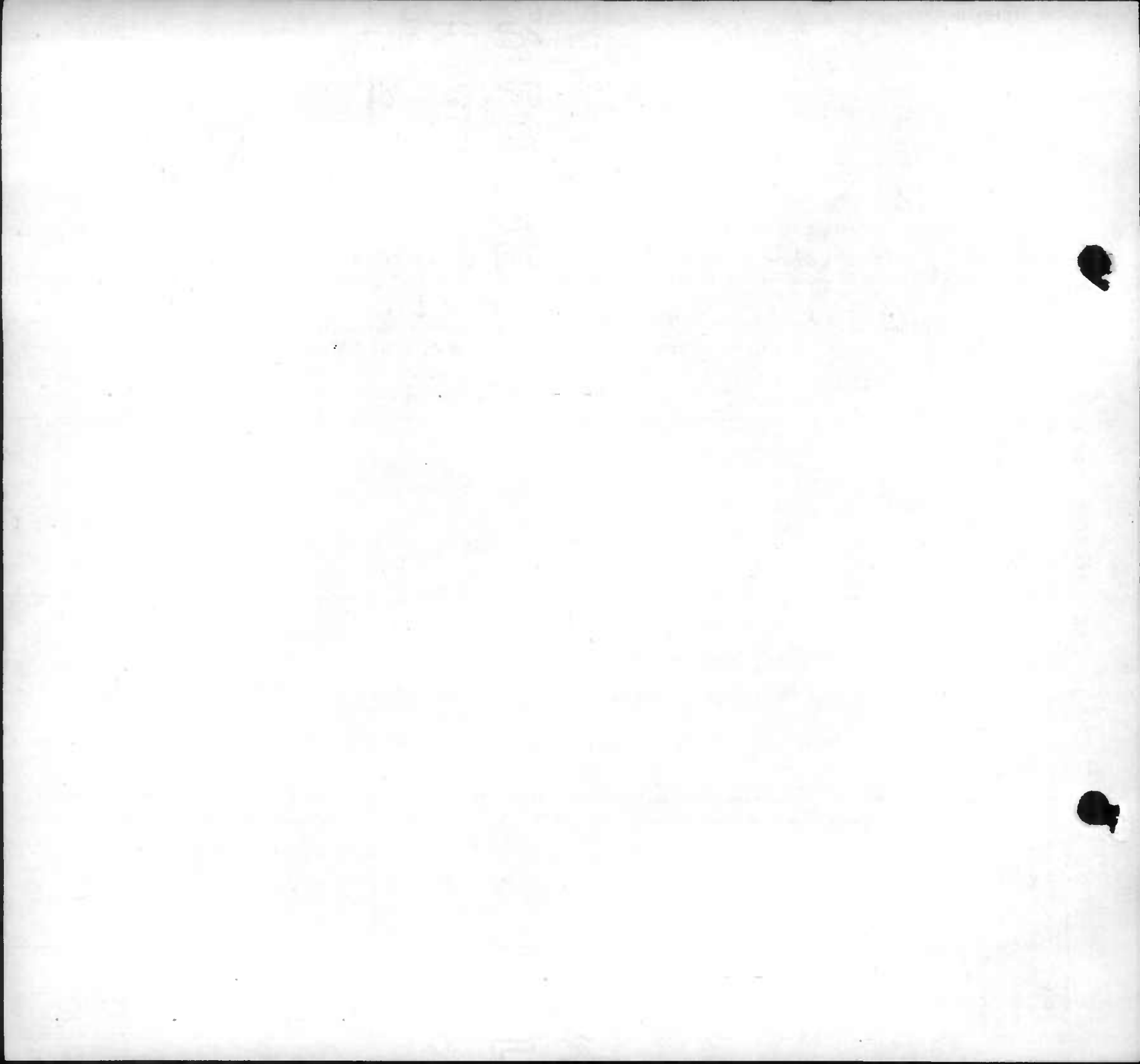
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Arlington Phillips 1727 N. Monroe St.

ADDRESS

APR 11 1968 Robert E. Phillips



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3896

REG. NO.

BIRTH NO.

1. NAME OF DECEASED *Lois D. Majette Brooks*  
(Type or Print) LOIS D. MAJETTE *Brooks*

2. DATE OF DEATH Known ☒ Month Day Year Hour  
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
Union Memorial Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour  
April 7, 1968 2:40 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

6. SEX Female 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 4-10-1947 10. AGE (In years last birthday) 21  
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER 1217 Linworth Avenue

11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Roy Boone

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME Arithia Brooks

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. 216-48-0326 18. INFORMANT ADDRESS Arthur L. Majette Same

19. E812.1 CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Massive hemoperitoneum DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Crushing injuries of liver DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) (Partial) Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 22C. WHERE DID INJURY OCCUR? North Avenue & Barkley Street 12-04

22D. TIME OF INJURY (APPROX.) 4-7-68 12:50 A. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Passenger in auto-auto collision

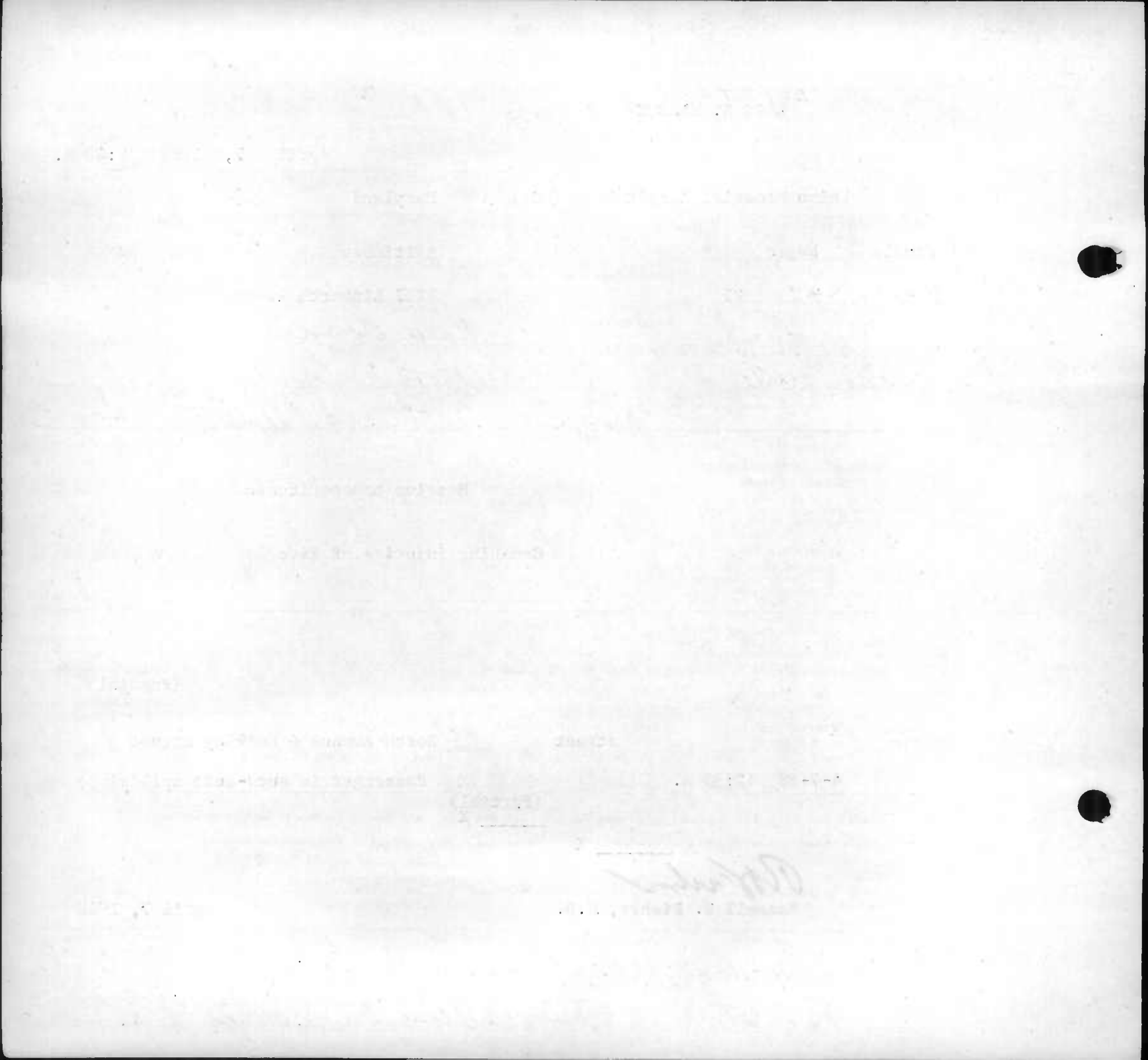
23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☒ DATE SIGNED April 7, 1968  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4-11-68 24C. NAME of CEMETERY or CREMATORY Archutus mem. Ch. Baltimore Md.  
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. APR 11 1968 25B. NAME OF REGISTRAR Robert E. Fisher 25C. FUNERAL DIRECTOR Address 1727 N. St. 1



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

# 68- 3897 CERTIFICATE OF DEATH

REG. NO.

68- 3897

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HAMILTON, ETHEL T.

2. DATE AND HOUR OF DEATH

4/7/1968 6:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2846, Clifton Ave.

5. SEX

F

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6-6-1895 72

9. AGE (In years last birthday)

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William Hunter

14. MOTHER'S MAIDEN NAME

Norma Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

212-32-2005

17. INFORMANT

William E. Hamilton Same

ADDRESS

18. 412.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C. V. A. + femoral embolism

(B) ASHCD = atrial fibrillation

DUE TO, OR AS A CONSEQUENCE OF:

(C).....

MEDICAL CERTIFICATION

443X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3/4/68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

RT. femoral embolism

20A. AUTOPSY? (Yes or No)

YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/24/1968 19 to 4/7/1968 19, that (I) (we) last saw the deceased alive on 4/7/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Kuro

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/7/68.

23C. PHYSICIAN'S NAME (Type)

DAVID KURO

23D. ADDRESS

LUTHERAN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial 4-11-68

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Ph. Cemetery

24D. LOCATION (City, town, or county)

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 11 1968

VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3898

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3898

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

McFARLANE

WILLIE

2. DATE AND HOUR OF DEATH

4-2

68

5:50

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒

NO ☐

E. STREET AND NUMBER

1055 W. Lexington ST 23

5. SEX

M.

6. RACE

N.

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

7/25/00

9. AGE (In years last birthday)

67

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virgin islands

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William McFarland

14. MOTHER'S MAIDEN NAME

does not remember

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218 01 8706

17. INFORMANT

Ethel McFarland Same

18. 3337 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Septicemia

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cerebral infarction 1 week

(C) DUE TO, OR AS A CONSEQUENCE OF:

Generalized arteriosclerosis

332X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 28 1968 to April 2 1968, that (I) (we) last saw the deceased alive on April 2 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Nak Joong Im

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

Nak Joong Im

23D. ADDRESS

Franklin Square Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial 4-5-68 Mt. Auburn

Baltimore MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

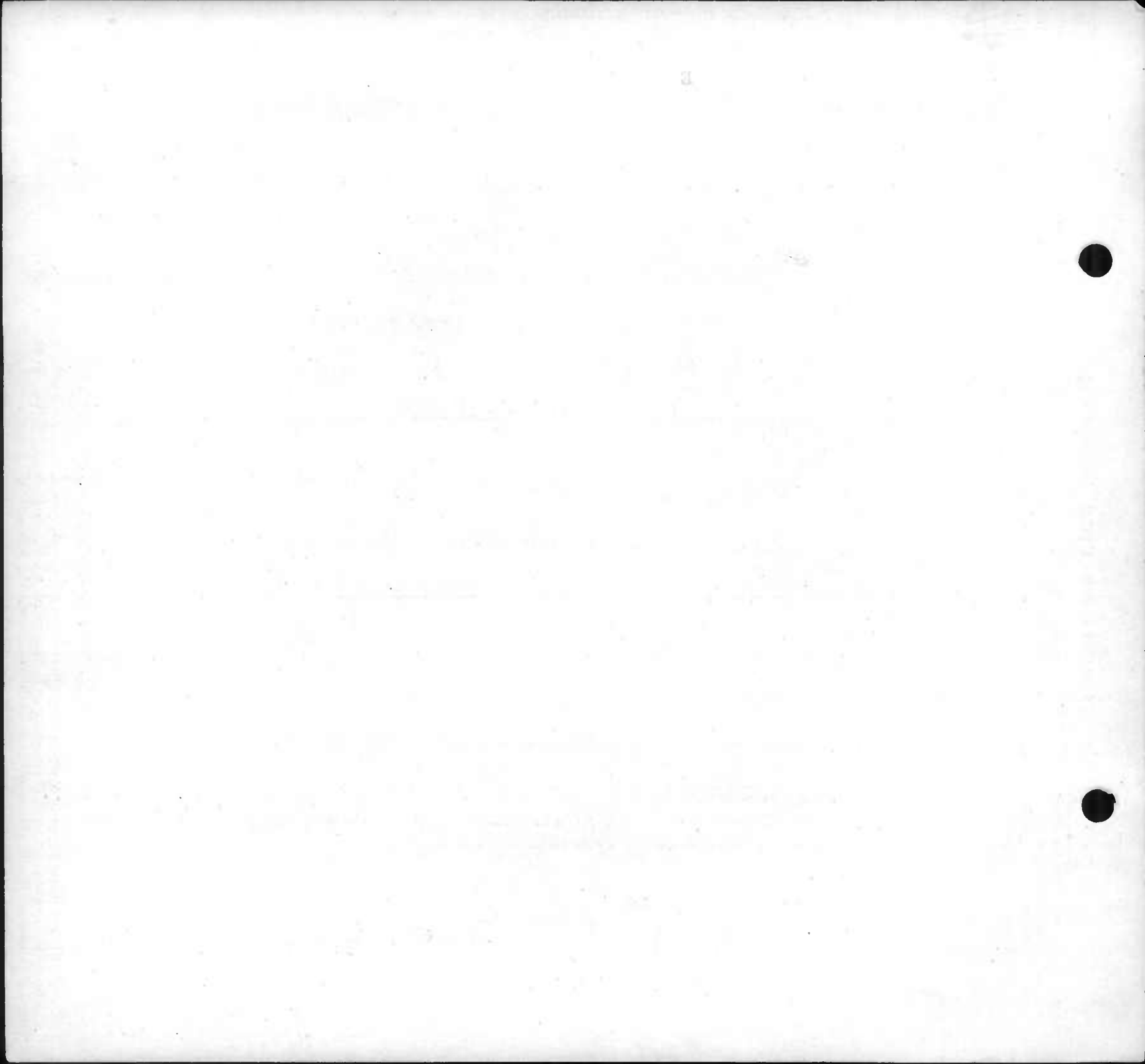
25C. FUNERAL DIRECTOR

ADDRESS

APR 11 1968

R. E. E. Farley

Wilmington, Delaware 17277



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3899

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3899

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HELEN R. HOWARD</b>		2. DATE AND HOUR OF DEATH <b>4-5-68 10<sup>25</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> E. STREET AND NUMBER <b>Brookfield Ave. 7529</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Jewish Convalescent Home</b>					
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/1916</b>	9. AGE (in years last birthday) <b>51</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Putzler Bro.</b>
13. FATHER'S NAME <b>Eddie Ragin</b>			14. MOTHER'S MAIDEN NAME <b>Louise Gable</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-12-4986</b>		17. INFORMANT <b>Mrs. Parnice Kent</b>	
18. <b>188X I</b>		CAUSE OF DEATH		ADDRESS <b>729 Annals Rd</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<b>General Carcinomatosis</b>		<b>2 mo.</b>	
ANTECEDENT CAUSES		(B) <b>Carcinoma of Lung &amp; Bladder</b>		<b>6 mo.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Metastasis to Lung &amp; Brain</b>		<b>3 mo.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/8/1968</b> to <b>4-5-1968</b> , that (I) (we) last saw the deceased alive on <b>4-5-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. A. Silver</b>				23B. DATE SIGNED <b>4-7-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. A. Silver M.D.</b>				23D. ADDRESS <b>6210 Park Heights Ave. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-10-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Ch. Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Wilmington Phillips</b>	
				ADDRESS <b>1111 N. E. St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 68-3900	
F-600 68-3900 <b>CERTIFICATE OF DEATH</b>											
1. NAME OF DECEASED (Type or Print) <b>Walter Albert Frey, Jr.</b>						2. DATE AND HOUR OF DEATH <b>April 9, 1968</b> <b>6:50 A. M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>919 Bellemore Road</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore 21210</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>919 Bellemore Road</b>					
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/4/1910</b>		9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. - Joffe Bros.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <b>Grocers</b>				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>						13. FATHER'S NAME <b>Walter A. Frey</b>					
14. MOTHER'S MAIDEN NAME <b>Helen Gilmore</b>						15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					
16. SOCIAL SECURITY NO. <b>212-07-8582</b>						17. INFORMANT <b>Mrs. Florence T. Frey</b>					
18. ADDRESS <b>(Same)</b>						19. CAUSE OF DEATH <b>157X-230.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>157X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Dying means</b>					
19A. DATE OF OPERATION <b>Jan 1968</b>						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cr 9 Pancreas</b>					
20A. AUTOPSY? (Yes or No) <b>No</b>						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>1956</b> to <b>April 9, 1968</b> , that (1) (we) last saw the deceased alive on <b>April 8, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Dr. Sylvan D. Goldberg</b>											
23B. DATE SIGNED <b>4/10/68</b>											
23C. PHYSICIAN'S NAME (Type) <b>Dr. Sylvan D. Goldberg</b>											
23D. ADDRESS <b>Medical Arts Bldg.</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>											
24B. DATE <b>4/11/68</b>											
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>											
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>											
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>											
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>											

Remembrance of Love

Dear Mother

Feb 14/23

My dear Mother

1/12/23

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3901</u>	
5-520 68-3901 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Wilmat A. SNOKE</u>			
2. DATE AND HOUR OF DEATH <u>April 10, 1968 7:15 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>37 Mercy Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital</u>			
6. CITY OR TOWN <u>BALTIMORE</u>		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
8. STREET AND NUMBER <u>608 Highwood Dr.</u>		9. SEX <u>M</u> 10. RACE <u>W</u> 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
12. DATE OF BIRTH <u>9-15-13</u>		13. AGE (In years last birthday) <u>54</u>			
14. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		15. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PURCHASING AGENT</u>		17. KIND OF BUSINESS OR INDUSTRY <u>PETROLEUM INDUSTRY</u>			
18. FATHER'S NAME <u>Jacob Arthur Snoke</u>		19. MOTHER'S MAIDEN NAME <u>Emma Florence CRAIG</u>			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWII</u>		21. SOCIAL SECURITY NO. <u>110-09-1313</u>		22. INFORMANT ADDRESS <u>MRS. MILDRED S. SNOKE (SAME)</u>	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>1533 I</u>		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinomatosis</u> (B) <u>Sigmoid carcinoma</u> (C) _____		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>mos-1yr.</u>	
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>1533 II</u>		27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Polycystic kidneys</u>		28. LIFE	
29. DATE OF OPERATION <u>2/20/68</u>		30. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma Sigmoid</u>		31. AUTOPSY? (Yes or No) <u>yes</u>	
32. A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		33. B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		34. C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
35. D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		36. E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		37. F. HOW DID INJURY OCCUR?	
38. I certify that (I) (this hospital) attended the deceased from <u>4/5/68</u> 19 to <u>4/10/68</u> 19, that (I) (we) last saw the deceased alive on <u>4/10/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
39. A. SIGNATURE <u>David S. McHold MD</u>		40. B. DATE SIGNED <u>4/11/68</u>		41. C. PHYSICIAN'S NAME (Type) <u>DAVID S. McHold</u>	
42. D. ADDRESS <u>MERCY HOSP.</u>		43. E. ADDRESS <u>Baltimore, Maryland</u>			
44. A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		45. B. DATE <u>4/15/68</u>		46. C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	
47. D. LOCATION <u>Baltimore, Maryland</u>		48. E. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>			
49. F. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		50. G. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</u>			

212-13-211

FORWARDING  
INSTRUCTIONS

W.W. II 11-11-11 11-11-11 11-11-11 11-11-11 11-11-11

Green Mountains

Japanese Consulate

Polish Consulate

2/20/18 11-11-11 11-11-11 11-11-11 11-11-11

4/10/18

4/10/18

4/10/18

David S. Mottola

WEEK 1029

David S. Mottola

Y-520 68-3902

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-3902

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HENRY YANCY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>711 N. Spring Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 7, 1968 7:15 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1002</b>	
9. DATE OF BIRTH <b>3-14-1918</b>		10. AGE (In years last birthday) <b>51</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Norfolk Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		13. FATHER'S NAME <b>Norfolk Yancy</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>YES</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Thomas Cunningham</b>		ADDRESS <b>2308 E. 16th Ave</b>	
19. CAUSE OF DEATH <b>5-7-181</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty liver</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>5-8-1-0 II</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>(Partial) Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-10-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cat</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore 21217</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Springate</b>	
25C. FUNERAL DIRECTOR <b>Charles S. Springate</b>		ADDRESS <b>10013 Ramble Hill</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3903	
W-452 68- 3903				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William H. Williams, Jr.		6 April 1968 16:30 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
38 Univ of Maryland		Md Baltimore			
		C. CITY OR TOWN D. INSIDE CITY LIMITS			
		Baltimore YES X NO			
		E. STREET AND NUMBER			
		551 Holston Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 5 1938	31	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Williams Sr		Mary Williams		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES				Chloe Williams Anne	
18. 431.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
		Prob Cerebral Hemorrhage 12 hrs.			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive Cerebral Vascular			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6 April 1968 to 6 April 1968, that (I) (we) lost saw the deceased alive on 6 April 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John Dm Eickbush M.D.				6 April 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John Dm Eickbush M.D.				Univ Md Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-10-68		Baltimore Cat	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 11 1968		Robert E. Farkner		Chap Wilson 1000 E. Baltimore Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-- 3904</u>	
D-300 68-- 3904				CERTIFICATE OF DEATH	
BIRTH NO. <u>D-300</u>		1. NAME OF DECEASED (Type or Print) <b>DOWDY ROBERT B</b>		2. DATE AND HOUR OF DEATH <b>APRIL 8, 1968 7:40 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE BALTO MD 21229</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-06</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>15-06</b> E. STREET AND NUMBER <b>1805 BLOOMINGDALE RD</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-15-04</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BOARD OF EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>CLEAM</b>		
14. MOTHER'S MAIDEN NAME <b>VIOLA ROACH</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212095942</b>			17. INFORMANT <b>CATON &amp; WILKENS BALTO MD 21229</b>		
18. CAUSE OF DEATH <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary Thromboses</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1 II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 23</b> 19 <b>68</b> to <b>APRIL 8</b> 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 8</b> 19 <b>68</b> and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> We) ( <input type="checkbox"/> did) ( <input checked="" type="checkbox"/> XXX) view the body after death.					
23A. SIGNATURE <i>Federico</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Policiano Federico</b>				23D. ADDRESS <b>BALTO, MD 21229 ST. AGNES HOSP; CATON &amp; WILKENS AVES.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Airy</b>	
24D. LOCATION (City, town, or county) (State) <b>Wilson</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Wilson</b>		25C. FUNERAL DIRECTOR <b>WILSON</b>			
25D. ADDRESS <b>2000 OL RANES ST</b>					



M-624 68- 3905 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. 68- 3905

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HAROLD MARSHALL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <b>April 8, 1968</b> 3:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>900 W. Lexington St. Apt. 12</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 8, 1968</b> 6:05 P.M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept 21-1942</b>		10. AGE (in years lost birthday) <b>25</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City Employee</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Grayson Marshall</b>		18. INFORMANT <b>Vernie Marshall</b>	
E. STREET AND NUMBER <b>1014 Brantley Avenue</b>		F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

19. <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive Subarachnoid Bleeding Originating from Aneurysm of Circle of Willis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <b>MASSIVE SUBARACHNOID BLEEDING</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/9/68</b>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-12-68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Cat</b>	24D. LOCATION (City, town, or county) (State) <b>Samuel Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 11 1968</b>	25B. NAME OF REGISTRAR <b>Reuben E. Feltner</b>	25C. FUNERAL DIRECTOR <b>Elroy De la Rosa</b>	ADDRESS <b>1000 Barclay St.</b>

WALTER D. BROWN

257 W. 10th St.

W. D. Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-362 68-3906				BALTIMORE CITY HEALTH DEPARTMENT		68-3906	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Waters, Daniel</u>				2. DATE AND HOUR OF DEATH <u>4/5/68</u> <u>6:30 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Nursing Home</u> <u>907 N. Carey St</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u>		B. COUNTY	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>8101 W. Cold Spring Lane</u>							
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-77</u>		9. AGE (In years last birthday) <u>90</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>UNKNOWN</u> ADDRESS			
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CORONARY THROMBOSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>720.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/17/67</u> 19 to <u>4/1/68</u> 19, that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4/8/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. [Signature]</u>				23D. ADDRESS <u>6519 Kennison Ave - Baltimore, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-13-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>E.O. Wilson 1000 Brantley Ave</u>			

10-18-72 90

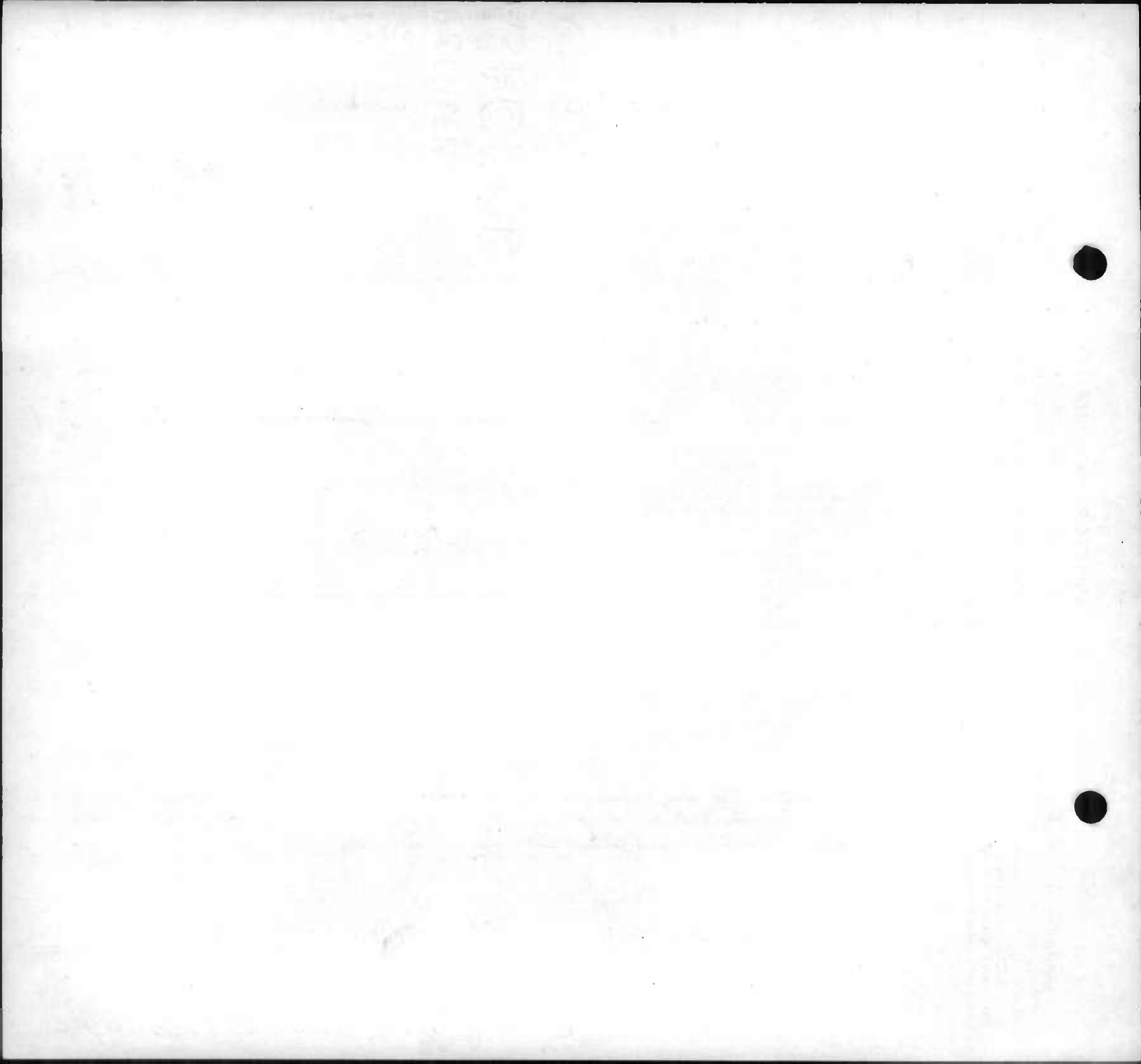
Greenway

James  
Blair

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

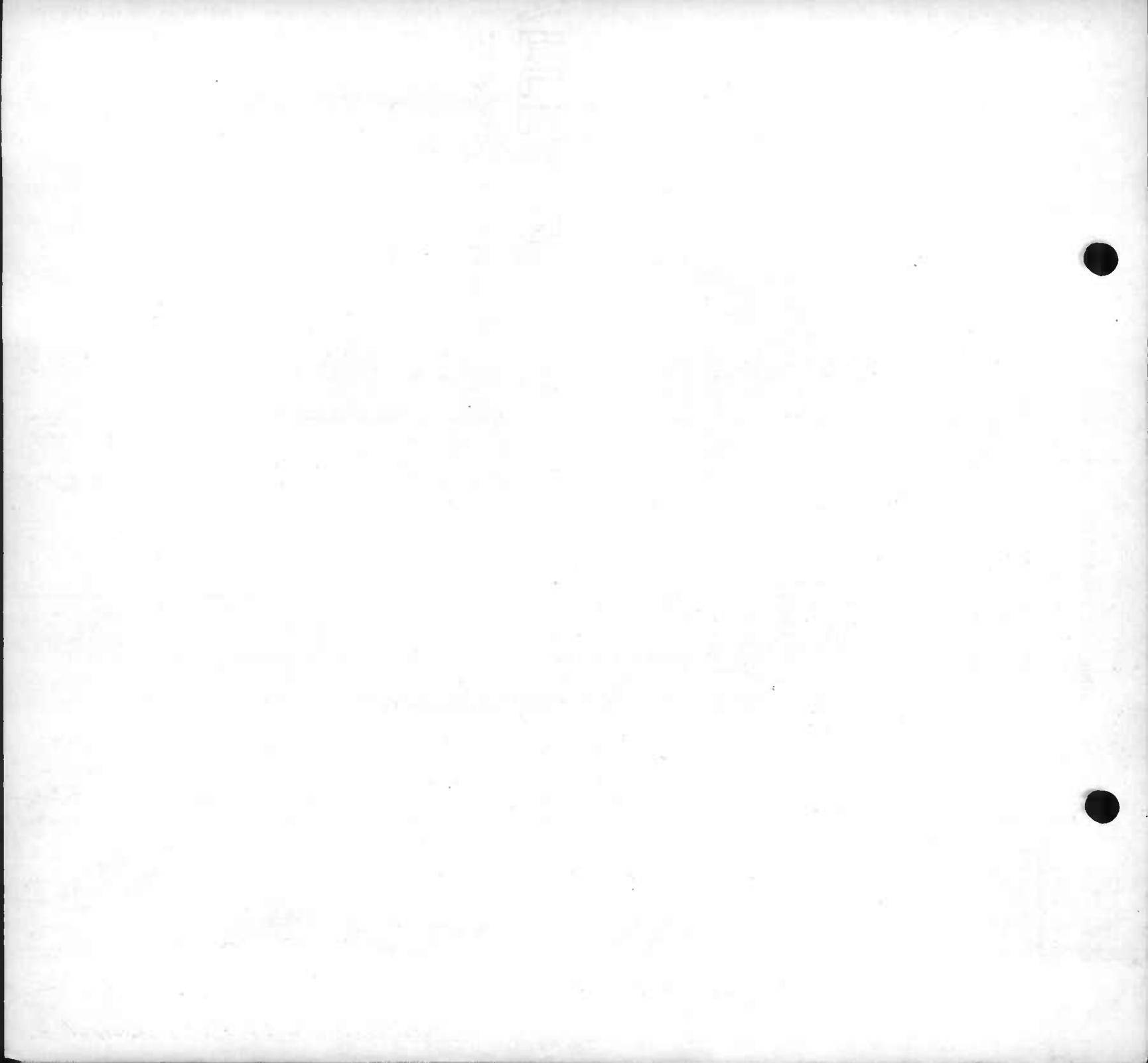
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3907</u>	
W-452 68-3907		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SALLIE WILLIAMS</u>		2. DATE AND HOUR OF DEATH <u>9 April 1968</u> <u>12:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u>		E. STREET AND NUMBER <u>625 Dolphin St. 31217</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-75</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>68-3907</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME <u>HAMPTON DUKES</u>		14. MOTHER'S MAIDEN NAME <u>SYLVIA JOHNSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beaufat Williams</u>	
18. <u>4129 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCD</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCD</u>			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>422.1 II</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>10 March</u> 19 <u>68</u> to <u>9 April</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>9 April</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jean M. Jackson, M.D.</u>				23B. DATE SIGNED <u>9 April 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>JEAN M. JACKSON, M.D.</u>				23D. ADDRESS <u>Univ. of Md. Hosp. Balto, Md. 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-13-68</u>		24C. NAME of CEMETERY or CREMATORY <u>mt Antons Cal</u>	
24D. LOCATION <u>Balto Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 11 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Jackson</u>	
24G. FUNERAL DIRECTOR <u>Beaufat Williams</u>		24H. ADDRESS <u>1000 Brewster Ave</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

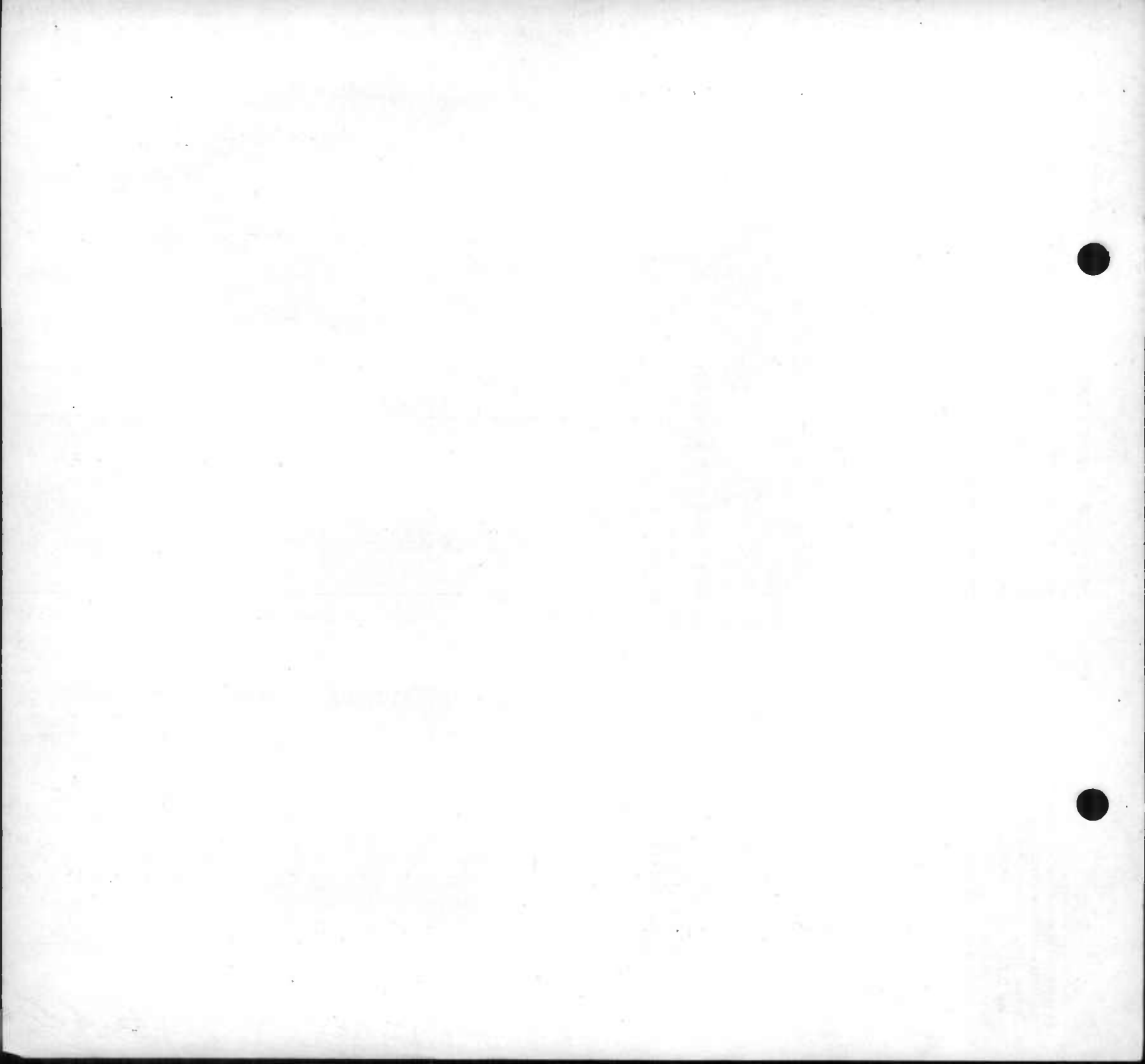
T-260		68- 3908		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3908	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Alice Lucke</i>				2. DATE AND HOUR OF DEATH <i>March 28 1968</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
<i>50924 Harlem Ave.</i>				<i>Maryland</i>		<i>Balto</i>	
5. SEX <i>Female</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>9-28-1899</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
<i>Housewife</i>							
13. FATHER'S NAME				14. BIRTHPLACE (State or foreign country)			
<i>Philip Tolson Sr</i>				<i>St Marys Md</i>			
15. Was Deceased in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<i>No</i>							
17. INFORMANT				ADDRESS			
<i>Philip Tolson Jr, Washington DC</i>				<i>Washington DC</i>			
18. <i>43110 I</i>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				<i>Cerebral Hemorrhage 32 yrs.</i>			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				<i>Hypertension</i>			
				(B) <i>Previous Stroke</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>331X II</i>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>June</i> 1966 to <i>Mar. 28</i> 1968, that (I) (we) lost saw the deceased alive on <i>Mar. 28</i> 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>D. M. K. Greasley M.D.</i>				<i>Apr. 10, 1968</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<i>D. M. K. Greasley</i>				<i>7576 - Dolphin St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4-5-68</i>		<i>St Luke Cmtg</i>		<i>Keittstown Md</i>	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<i>APR 11 1968</i>				<i>Robert E. Taylor</i>		<i>Shay Wilson 1000 Cranberry Ave</i>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

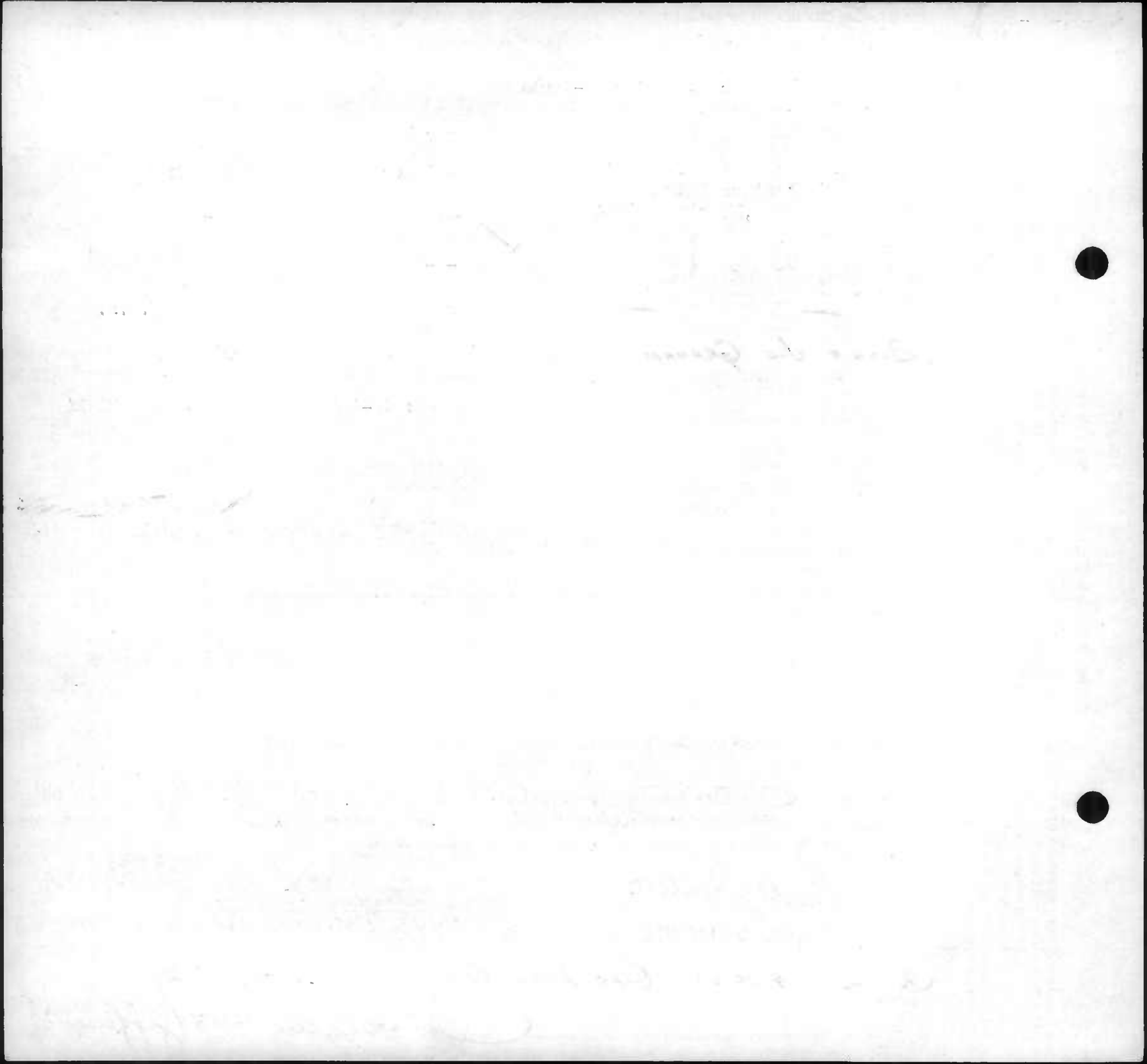
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	68- 3909
<div style="display: flex; justify-content: space-between;"> <span>K-2610</span> <span>68- 3909</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>Helen B Kager</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <i>April 9 1968 5:30 P. M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>1112 N. Port St.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-07-979</i>		17. INFORMANT <i>Charles E Kager</i>	
18. <i>410.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.1 II</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Coronary occlusion</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
(B) <i>Cordis Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF:		(C) <i>Hypertension</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <i>4/6</i> 19 <i>68</i> to <i>4/9</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/9</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert R. Laforest MD</i>				23B. DATE SIGNED <i>4/10/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFOREST</i>		23D. ADDRESS <i>822 N. Bond St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-13-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Carmel Cmt</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 11 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Shoy W. Johnson</i>			
25D. ADDRESS <i>1300 Blount Ave</i>					



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620 68-3910		BIRTH NO. 68-06300		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3910	
1. NAME OF DECEASED (Type or Print) Baby Girl Morris-Paula				2. DATE AND HOUR OF DEATH April 8, 1968 10:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 807 North Montford Avenue 21205			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1968	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BONNIE JOE GRAHAM				14. MOTHER'S MAIDEN NAME Paula Morris			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Records: BCH-4940 Eastern Avenue		21224	
18. 722.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST - 2 min (B) CENTRAL NERVOUS SYSTEM BLEEDING - 2 1/2 hrs (C)			
19. 760.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 8, 1968 to April 8, 1968, that (I) (we) last saw the deceased alive on April 8, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Raquel V. Montezuma, M.D.				23B. DATE SIGNED April 8, 1968			
23C. PHYSICIAN'S NAME (Type) RAQUEL V. MONTEZUMA, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 EASTERN AVENUE - BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-10-68		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR J. Miller		ADDRESS - 2334 Jefferson St	



## 68- 3911 CERTIFICATE OF DEATH

REG. NO.

68- 3911

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA QUATY

2. DATE AND HOUR OF DEATH

4-12-68 1:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2924 McELDERY ST.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8-9-1884

9. AGE (In years  
last birthday)

83

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ALBERT FREIDEL

14. MOTHER'S MAIDEN NAME

LOUISE SCHNEEMANN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

H. Wilbur E. Quaty - 2924 McEldey St.

18. 182.9 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-11-1968 to 4-12-1968,  
that (I) (we) last saw the deceased alive on 4-12-1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

LEONARDO A. TADALAN, M.D.

23D. ADDRESS

MERCY HOSP.

23B. DATE SIGNED

4-12-68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-15-68

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN CEM.

24D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Fasham

25C. FUNERAL DIRECTOR

Quaty Miller - 2334

ADDRESS

Jefferson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

10/10/10  
10/10/10

10/10/10

10/10/10

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3912

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68-3912

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRED J. ARBOGAST

2. DATE AND HOUR OF DEATH

4-12-68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MELCOUR NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

E. STREET AND NUMBER

2407 E. MADISON ST.

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-18-1886

9. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JACOB ARBOGAST

14. MOTHER'S MAIDEN NAME

ROSE NEUSBAUM

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217 07 2225

17. INFORMANT

Mr. Walter W. Arbogast

ADDRESS

5607 Wimmer

18. 4-10-9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

acute M. Infarction

chronic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

A.S.C.V.D.

(C)

19. 4-20-1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Brachitis, Bronchitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on

and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Morton U. Ellin

DEGREE

Attending  
Phys.

Med.  
Director

Staff  
Phys.

23B. DATE SIGNED

4/13/68

23C. PHYSICIAN'S  
NAME (Type)

Morton U. Ellin, M.D.

23D. ADDRESS

8629 Liberty Road, Randallstown, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

4-15-68

24C. NAME OF CEMETERY OR CREMATORY

LOUDON PK. Cem.

24D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

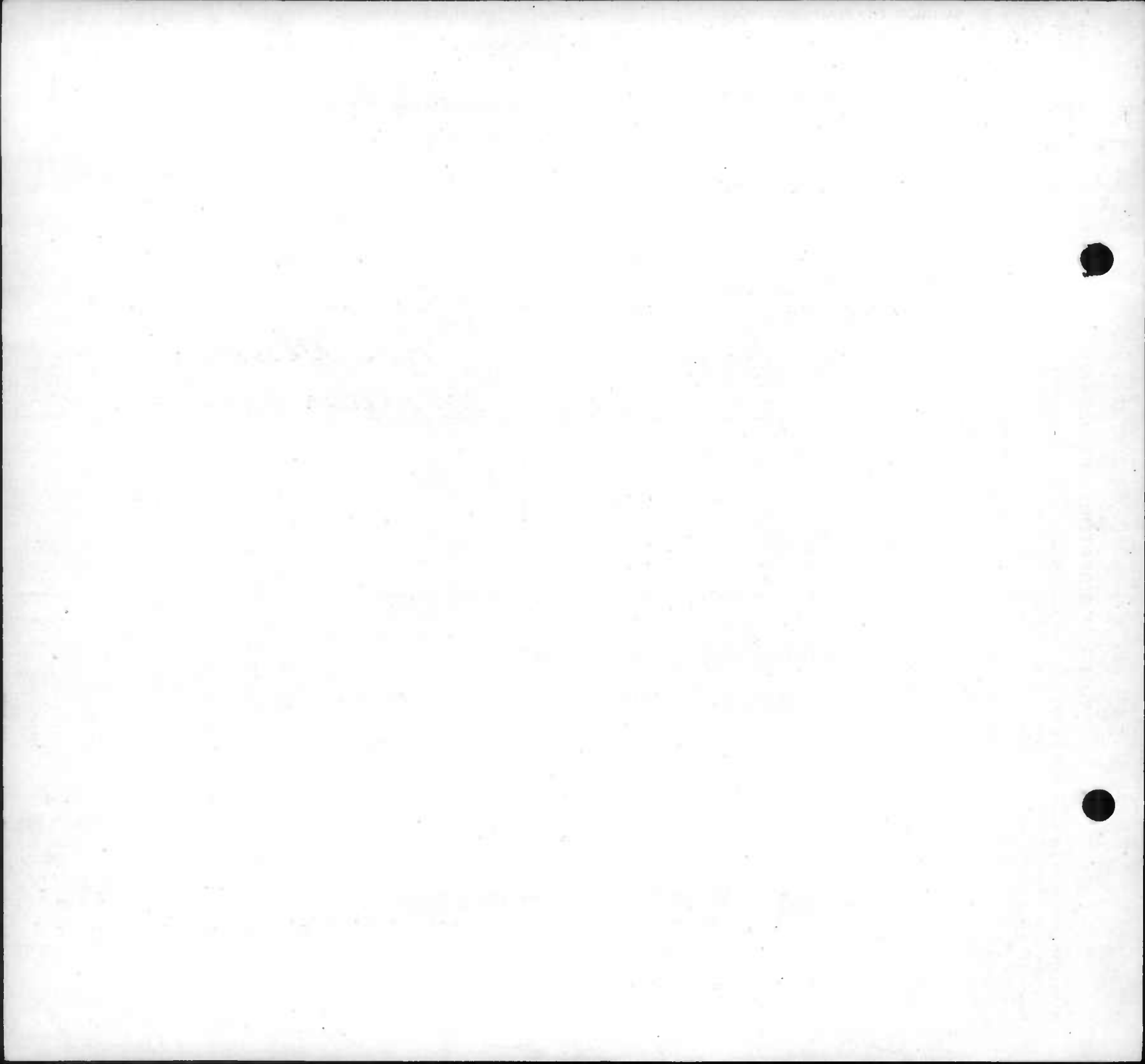
25C. FUNERAL DIRECTOR

ADDRESS

APR 15 1968

R. E. F. F.

Garth Miller - 2334 Jefferson St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3913
BIRTH NO. 68-06275		68-3913		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) SOUTHARD, Paul A.		2. DATE AND HOUR OF DEATH 4/10/68 1:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 110 Lamport Rd. 53-00		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/68	9. AGE (In years last birthday) 26
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Sinai Hosp. - Balto. Md. U.S.A.	
13. FATHER'S NAME Wayne D. Southard		14. MOTHER'S MAIDEN NAME Patricia A. DePaul		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS 110 Lamport Rd., Wayne Southard Reisterstown, Md.	
18. 74691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anoxia (B) MULTIPLE, CONGENITAL CARDIAC MALFORMATIONS DUE TO, OR AS A CONSEQUENCE OF: (C) ---		
19. 7545 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 4/9/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac catheterization	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) April 10, 1968 1:15 P.M.	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/9/68 to 4/10/68, that (I) (we) last saw the deceased alive on 4/10/68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Jan A. Elliott, M.D.		23B. DATE SIGNED 4/10/68		23C. PHYSICIAN'S NAME (Type) Dr. Jan A. Elliott, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 12, 1968		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery
24D. LOCATION Woodlawn, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. APR 18 1968		
25B. NAME OF REGISTRAR Robert E. Jackson, M.D.		25C. FUNERAL DIRECTOR H. J. Edhardt		
25D. ADDRESS Owings Mills, Md.				

4/2/68 1st  
Genee trip

Curran

Multiple, congenital cardiac  
malformations

4/9/68 Cardiac catheterization

1st

Genee 1st trip 1/2

1/2 collection

4/10

4/14

4/15

4/16

4/16/68  
Genee trip

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3914 CERTIFICATE OF DEATH

REG. NO. 68- 3914

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HERMAN J. WIESNER JR

2. DATE AND HOUR OF DEATH

4/7/68

6 35 A M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL OF BALTIMORE INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY BALT.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

5803 MERVILLE AVENUE

5. SEX

M

6. RACE

CAU

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

6/4/14

9. AGE (In years lost birthday)

53

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BALT. GAS & ELECTRIC CO - Engineer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Herman J. Wiesner Sr

14. MOTHER'S MAIDEN NAME

Thelma A. Rush

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown No.

16. SOCIAL SECURITY NO.

212-054395

17. INFORMANT

Mrs. Thelma A. Wiesner

ADDRESS

5803 Merville Ave Balto. Md. 21215

18.

4-12-0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY & CARDIAC DEPRESSION 12 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) SUBARACHNOID HEMORRHAGE 3 DAYS

(C) HYPERTENSIVE CARDIOVASCULAR DISEASE 4 WEEKS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

443X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 4/3/68 to 4/7/68, that (we) last saw the deceased alive on 4/7/68, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald Datch MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/7/68

23C. PHYSICIAN'S NAME (Type)

RONALD DATCH MD

23D. ADDRESS

SINAI HOSPITAL BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-11-68

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 10 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

LORING BYERS - 8728 Liberty Road

ADDRESS

1912

John A. R.

1912

John A. R.

John A. R.

John A. R.

John A. R.

John A. R.

John A. R.

John A. R.

John A. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT

## 68-3915 CERTIFICATE OF DEATH

REG. NO. 68-3915

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RAYMOND W. BRYANT

2. DATE AND HOUR OF DEATH

4-8-68 5:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3019 Spaulding Ave  
Balto. Md. 21215

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

3019 Spaulding Ave

5. SEX

Male

6. RACE

White

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

8-14-1894

9. AGE (in years last birthday)

75

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Race Track

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ranson Janner Bryant

14. MOTHER'S MAIDEN NAME

Martha Jane Cole

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-26-9712

17. INFORMANT

Mrs. Florence L. Bryant

ADDRESS

3019 Spaulding Ave Balto. Md. 21215

18. 410.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

CORONARY OCCLUSION

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

CORONARY INSUFFICIENCY

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

ACUTE

7 1/2 years

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Aug 20 1960 to April 8 1968, that (I) (~~we~~) last saw the deceased alive on April 4 1968, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (~~did not~~) view the body after death.

23A. SIGNATURE

Gilbert E. Rudman, M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/11/68

23C. PHYSICIAN'S NAME (Type)

GILBERT E. RUDMAN, M.D.

23D. ADDRESS

4701 Liberty Hts. Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/12/68

24C. NAME OF CEMETERY OR CREMATORY

Lake View Memorial Park

24D. LOCATION

(City, town, or county) (State)

Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Loring Byers - 8728 Liberty Road

ADDRESS

3/1/1914

12 11-12-14

Good luck

Good luck

Good luck

2-1-14

12 11-12-14

Good luck

Good luck

Good luck

Good luck

1  
L-256

68- 3916

BALTIMORE CITY HEALTH DEPARTMENT

68- 3916

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GORDON C. LOCHNER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 7, 1968</b>		Hour <b>12:45 p.m.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 7, 1968</b>		Hour <b>12:45 p.m.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH <b>Feb. 23, 1916</b>		10. AGE (In years last birthday) <b>52</b>		E. STREET AND NUMBER <b>5504 Relcrest Rd. Apt. A</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Leonard Lochner</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk -</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co</b>		15. MOTHER'S MAIDEN NAME <b>Mari'e Haesloop</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-05-9190</b>		18. INFORMANT <b>Mrs. Florentina M. Lochner</b> <b>5504 Relcrest Rd. Balto. Md.</b>
19. <b>4/12/68</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <b>4/11/68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>4-8-68</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Norming Byars - 8728 Liberty Road</b>		

X

3rd 33 MIP

Belle Mead

Clark -

10

U.S.A.

Bell & Howell Co

2nd 22 MIP

Edmund Kocher

James H. Haegele

2nd 22 MIP

Revised 4/1/82

Don't Ruffe

J. Brown, Jr.

Xerox 8000-8000

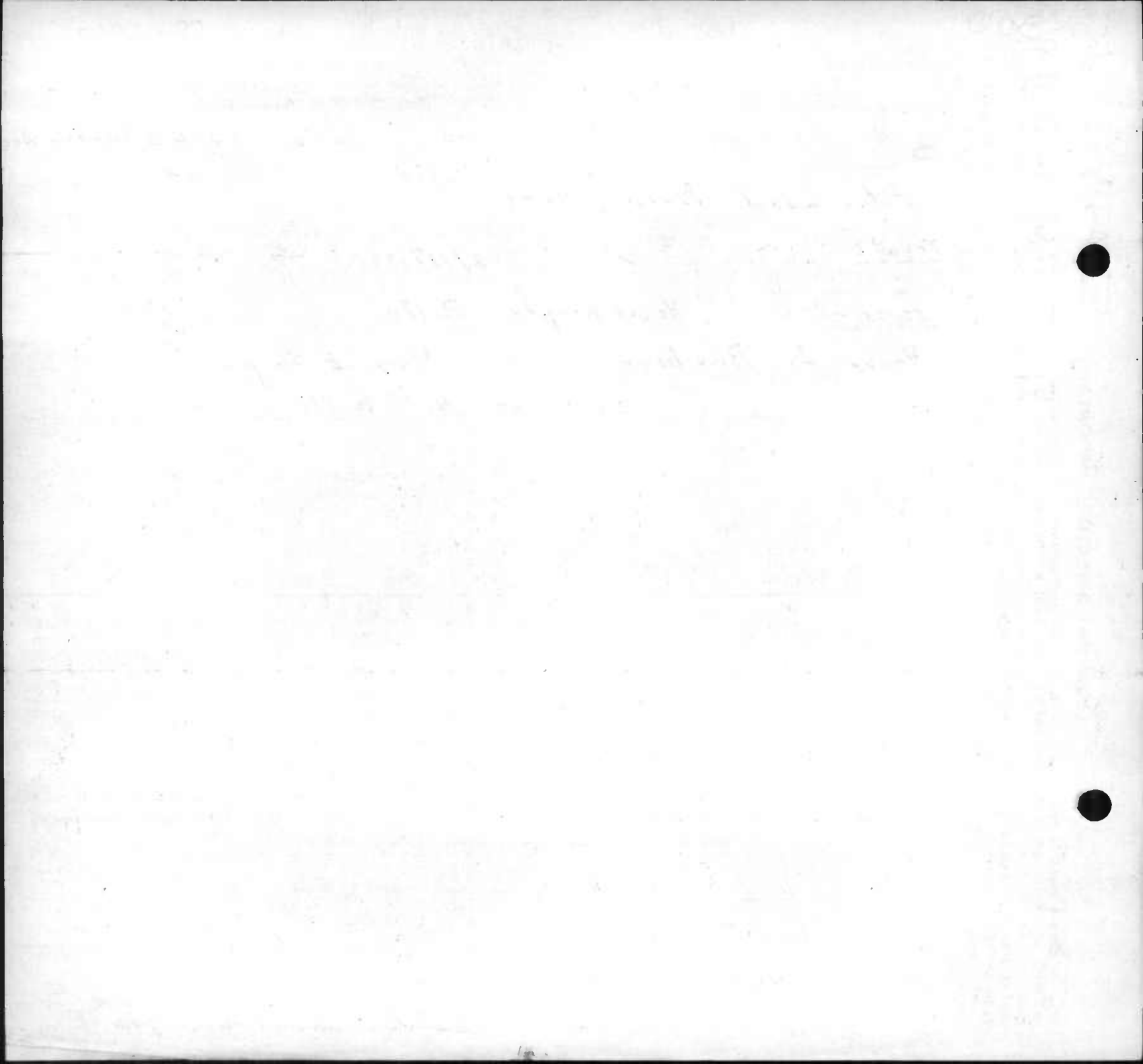
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death; and (6) No physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3917

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 68-3917

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ESTELLE MUTH</b>		2. DATE AND HOUR OF DEATH <b>April 8 1968 6:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> 8. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Edge wood Nursing Home</b>				C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3203 Taylor Ave</b>				F. STREET AND NUMBER <b>2105</b>	
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/1890</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home Keeper</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Henry L. Barbours</b>			
14. MOTHER'S MAIDEN NAME <b>Mary E Sapp</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>218-18-384</b>		17. INFORMANT <b>Mr. William Barbours</b>			
18. CAUSE OF DEATH <b>457.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>394X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3+yr</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cerebral cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>394X II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 24 1964</b> to <b>Apr 7 1968</b> , that (I) (we) last saw the deceased alive on <b>Mar 27 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frederick J. Vollmer MD</b>				23B. DATE SIGNED <b>April 8, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK J VOLLMER</b>				23D. ADDRESS <b>6100 York Rd, Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/10/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <b>John E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Jessie J. Samuel Thomas 7801 Belair Rd.</b>			



68- 3918 CERTIFICATE OF DEATH

REG. NO. 68- 3918

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Ralph Thomas Prado

2. DATE AND HOUR OF DEATH

April 9, 1968

12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)US Public Health Service  
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN

Hyattsville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5812 Lamont Drive

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2/14/18

9. AGE (In years  
last birthday)

50

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

2nd Asst. Eng.

10B. KIND OF BUSINESS OR INDUSTRY

Steam ship line

11. BIRTHPLACE (State or foreign country)

Virgin Islands

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Felipe Prado

14. MOTHER'S MAIDEN NAME

Gabriella Gomez

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

057-14-3782

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

2262 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Craniopharyngeoma

Months

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

224X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

no

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar. 4 1968 to Apr. 9 1968.  
that (I) (we) last saw the deceased alive on Apr. 9 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Henry S. Crist, M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4/9/68

23C. PHYSICIAN'S  
NAME (Type)

Henry S. Crist, SA Surg (R)

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/12/68

24C. NAME OF CEMETERY or CREMATORIUM

Ft Lincoln Cemetery

24D. LOCATION

(City, town, or county)

Colmar Manor Pro Geo

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

F. Gasch's Sons

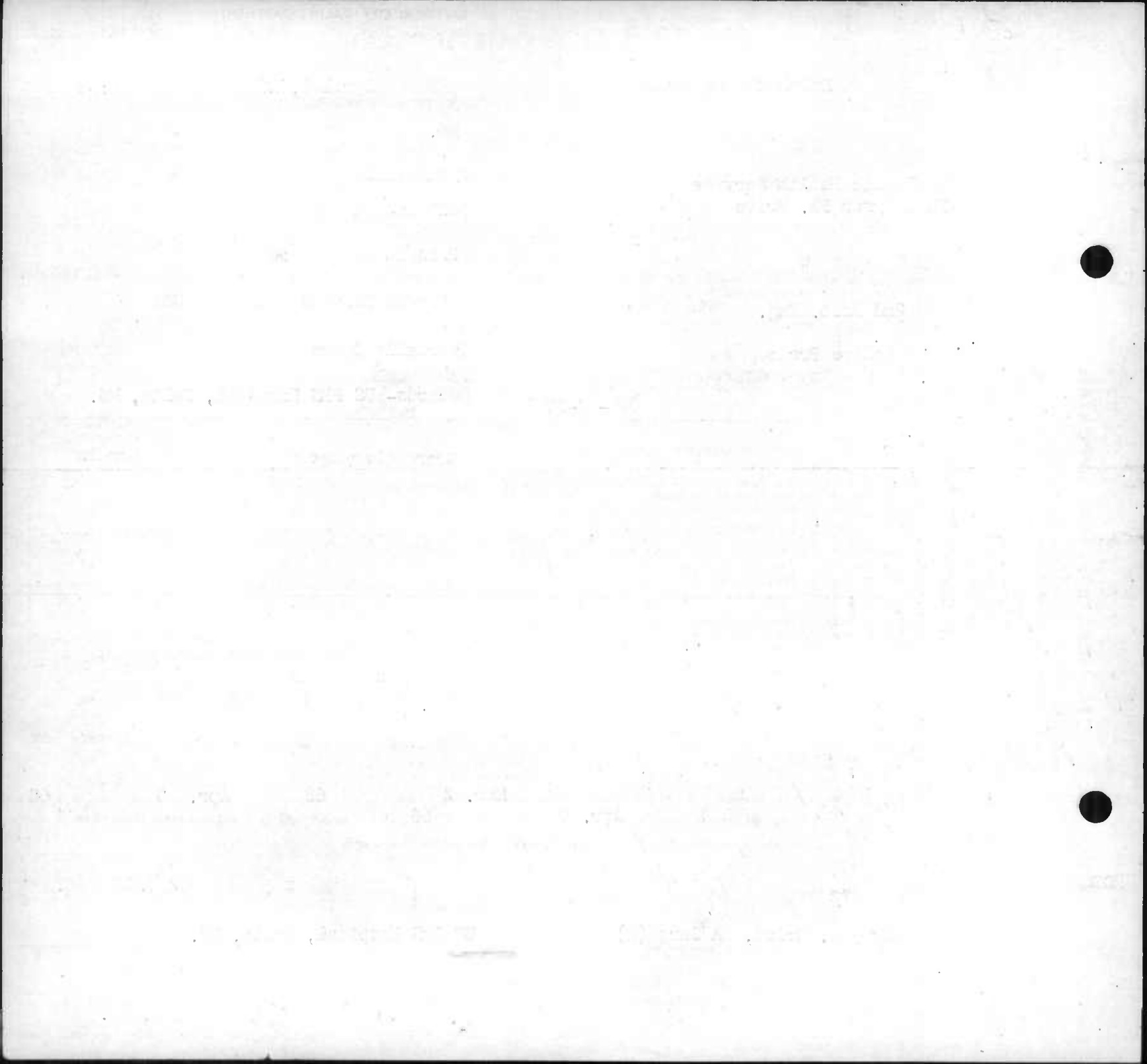
ADDRESS

Hyattsville, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3919

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3919

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cicero Jordan

2. DATE AND HOUR OF DEATH

4/8/68 4:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Md. Gen. Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md. BA/to City

C. CITY OR TOWN

D. INSIDE-CITY LIMITS?

BA/to

YES ☒

NO ☐

E. STREET AND NUMBER

1404 Eutan Place

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

m w

WIDOWED ☐ DIVORCED ☐

11/21/1900 67

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired

Retired

Ala.

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Unknown

Lotte

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Yes WWI

414-03-4685

Hosp Charge Wif Elizabeth Jordan 1404 Eutan Pl

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐

Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 3/31 1968 to 4/3 1968, that (I) (we) last saw the deceased alive on 4/3/ 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. P+ WAS D.O.A.

23A. SIGNATURE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/8/68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DAVID E. ZICKAFOOSE

Md. Gen. Hosp - E.R.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

4-12-68

Jordan Park Cemetery Frederick Ave Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 10 1968

Robert E. Jackson

Jack Lewis 2100 Eutan Pl.

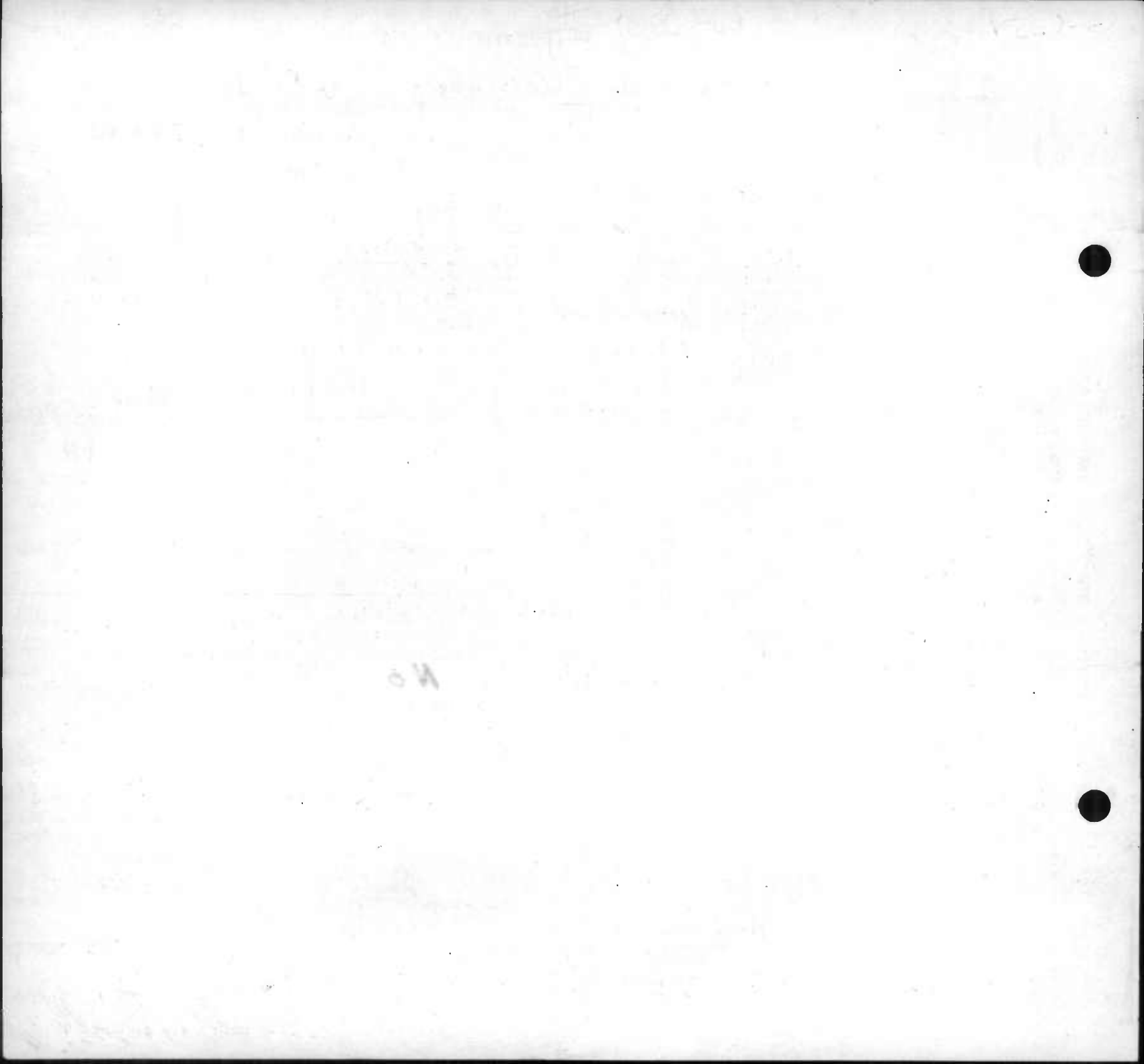
100 000

4-12-66 Gordon Park Cemetery, Portland, Me.  
Back Street, Portland, Me.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3920</u>
68-3920				CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MR. ANNA Jane Greenberg		4/5/68 8P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Montebello Hosp		A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Pikesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 506 Milford Mill Rd		F. ZIP CODE 53-00		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1896	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife own home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo
13. FATHER'S NAME Louis Heisman		14. MOTHER'S MAIDEN NAME Charlotte Kalb		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Husband JACOB GREENBERG
18. 4/10/91		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD		
420.1 II		(C) DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1d		
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? 0		
22. I certify that (I) (this hospital) attended the deceased from 12/15/1966 to 4/5/1968, that (I) (we) lost saw the deceased alive on 4/5/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Hea Rean LEW		23B. DATE SIGNED 4/5/68		
23C. PHYSICIAN'S NAME (Type) Hea Rean LEW		23D. ADDRESS Montebello Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE April 8, 1968	24C. NAME of CEMETERY or CREMATORY New Catholic Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 15 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank H. Jewell
				ADDRESS Pikesville 8, Md.



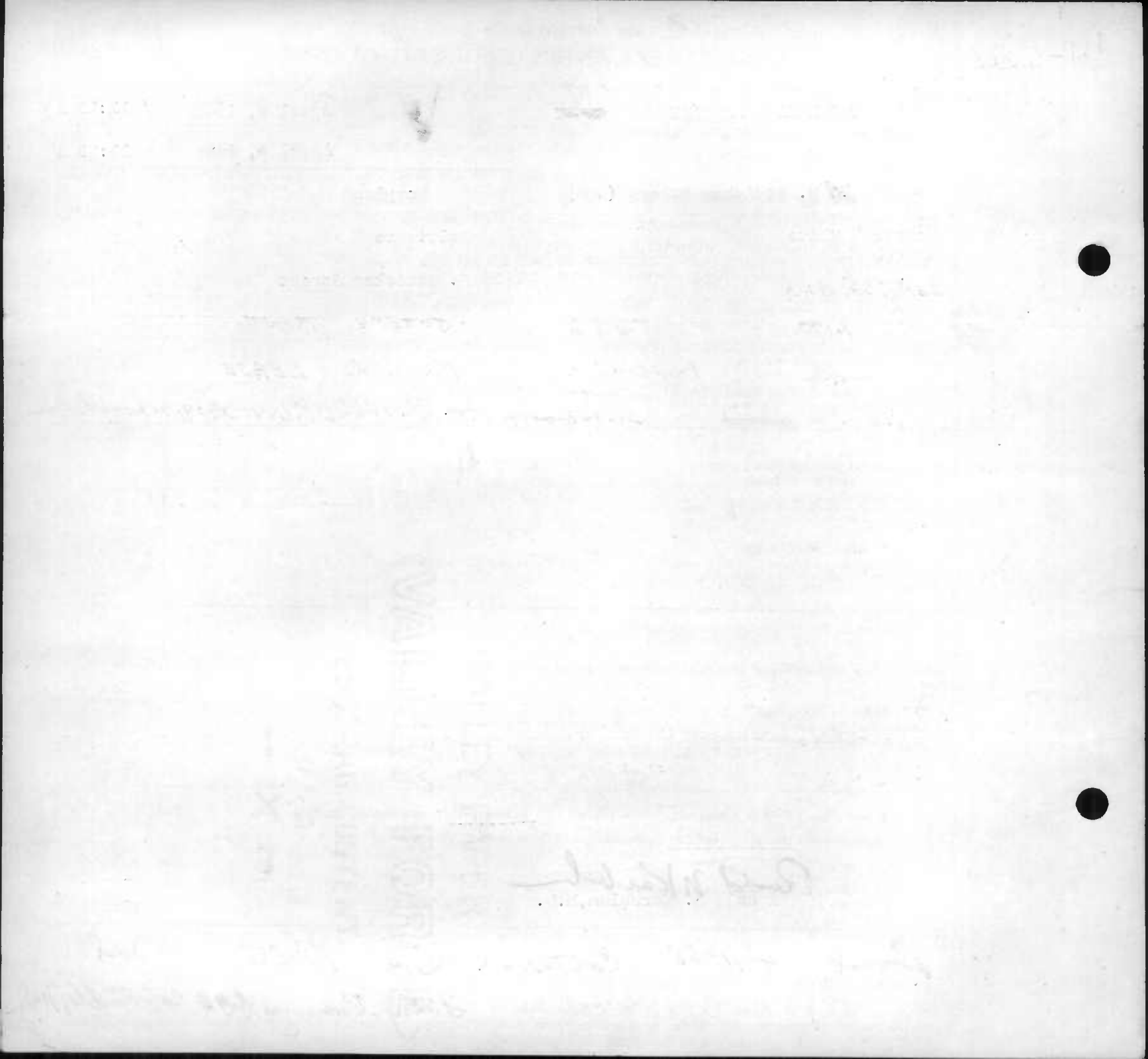
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3921

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PATRICIA MARKLEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>April 8, 1968</b>		Hour <b>12:23 A.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>29 S. Stricker Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 8, 1968</b>		Hour <b>12:23 A.</b>
6. SEX <b>Female</b>		7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>SEPT. 24, 1943</b>		10. AGE (in years lost birthday) <b>24</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH KING</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY
15. MOTHER'S MAIDEN NAME <b>FRANCES LEASE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-58-4444</b>
18. INFORMANT <b>Mr. James KING - 2909 J. Stricker St.</b>		19. CAUSE OF DEATH <b>Acute Ethylism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Ethylism</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION <b>303.91</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4-8-68</b>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>4-80</b>
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-11-68</b>
24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cem.</b>		24D. LOCATION (City, town, or county) <b>Balti.</b>		(State) <b>Ind.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, Jr.</b>		25C. FUNERAL DIRECTOR <b>Foley - Cronough &amp; H. Catonsville, Md.</b>



T-100

68-3922

BALTIMORE CITY HEALTH DEPARTMENT

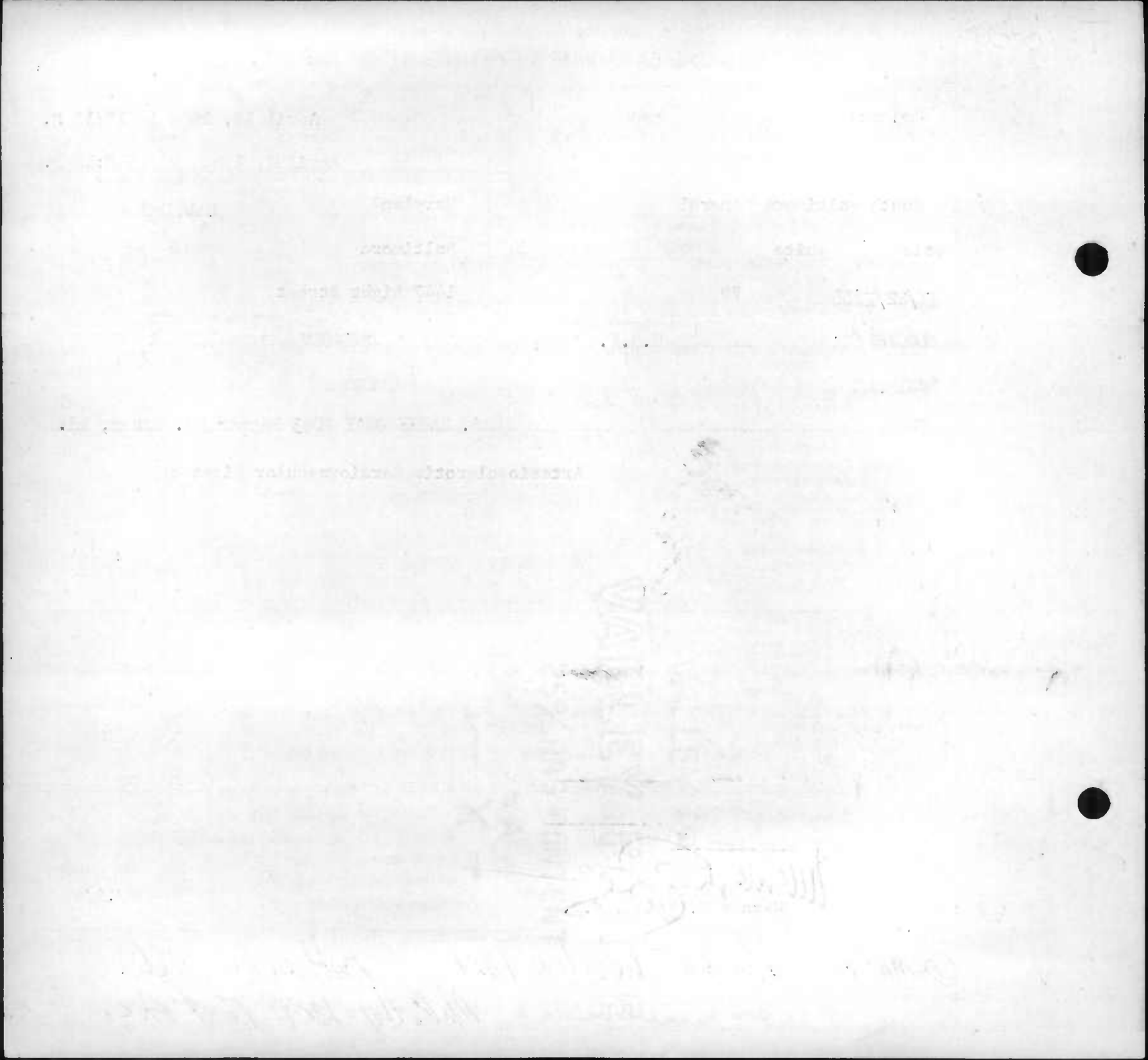
68-3922

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE P TOBY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 12, 1968</b> 12:15 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 12, 1968</b> 12:15 P.M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11/22/1888</b>		10. AGE (in years last birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MRS. MARIE GRAY TOBY</b>		ADDRESS <b>1043 Baynor Rd. Essex, Md.</b>	
19. <b>412.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-22-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>4/13/68</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>		24B. DATE <b>4/15/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Louder Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>McElly 4-130 E. Fort Ave.</b>		ADDRESS	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3923

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3923

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Frank Earl Edward Francis Earl</i>		2. DATE AND HOUR OF DEATH <i>4/7/68 5:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i>		5. SEX <i>Male</i> 6. RACE <i>White</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
E. STREET AND NUMBER <i>2100 BARCLAY STREET</i>		8. DATE OF BIRTH <i>4/9/1886</i>		9. AGE (In years last birthday) <i>81 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bricklayer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i>		11. BIRTHPLACE (State or foreign country) <i>New York, Washington D.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A. America</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES World War I</i>		16. SOCIAL SECURITY NO. <i>123-09-0162A</i>		17. INFORMANT <i>Mrs Sarel Wolder</i>	
18. CAUSE OF DEATH <i>Bilateral Pneumonia, pleural effusion</i>		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Antecedent Causes</i>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Prostatic CA metastases</i>	
21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Prostatic Carcinoma</i>		22. I certify that (this hospital) attended the deceased from <i>2/8/68</i> to <i>4/7/68</i> and that (I) last saw the deceased alive on <i>4/6/68</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. DATE SIGNED <i>4/7/68</i>	
23A. SIGNATURE <i>Dermot Campbell M.D.</i>		23B. DATE SIGNED <i>4/7/68</i>		23C. PHYSICIAN'S NAME (Type) <i>DERMOT CAMPBELL M.D.</i>	
23D. ADDRESS <i>Union Memorial Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-11-1968</i>	
24C. NAME OF CEMETERY or CREMATORY <i>BALTO. U.S. NATIONAL</i>		24D. LOCATION <i>5501 Frederick Rd. BALTO., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Tanbury</i>		25C. FUNERAL DIRECTOR <i>J. Walter Cribben</i>		25D. ADDRESS <i>5444 BELAIR Rd. 21206</i>	

Received of Mr. J. H. ...  
the sum of ...  
for ...

Witnessed  
at ...  
this 1st day of ...  
1901

Done at ...  
this 1st day of ...  
1901

D-553

68-- 3924

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-- 3924

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GRACE DIAMOND</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 9, 1968</b> 10:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1138 W. Pratt Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 9, 1968</b> 12:35 P.M.	
6. SEX <b>female</b>	7. RACE <b>white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>
9. DATE OF BIRTH <b>8/19/1909</b>	10. AGE (In years lost birthday) <b>58</b>	11. BIRTHPLACE (State or foreign country) <b>unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cleaning</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>dry cleaning</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>120-18-8313</b>	
18. INFORMANT <b>Mrs. Vera Knapp</b>		ADDRESS <b>5501 Symon Ave. (21227)</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>4-22-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>No</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/9/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/11/1968</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>	25C. FUNERAL DIRECTOR <b>John J. Cowan &amp; Son, Inc.</b>	ADDRESS <b>901 Hollins St. (Baltimore Md. 21223)</b>

Handwritten signature and stamp, possibly reading "J. J. [illegible]".

FUNERAL DIRECTOR: IMPORTANT

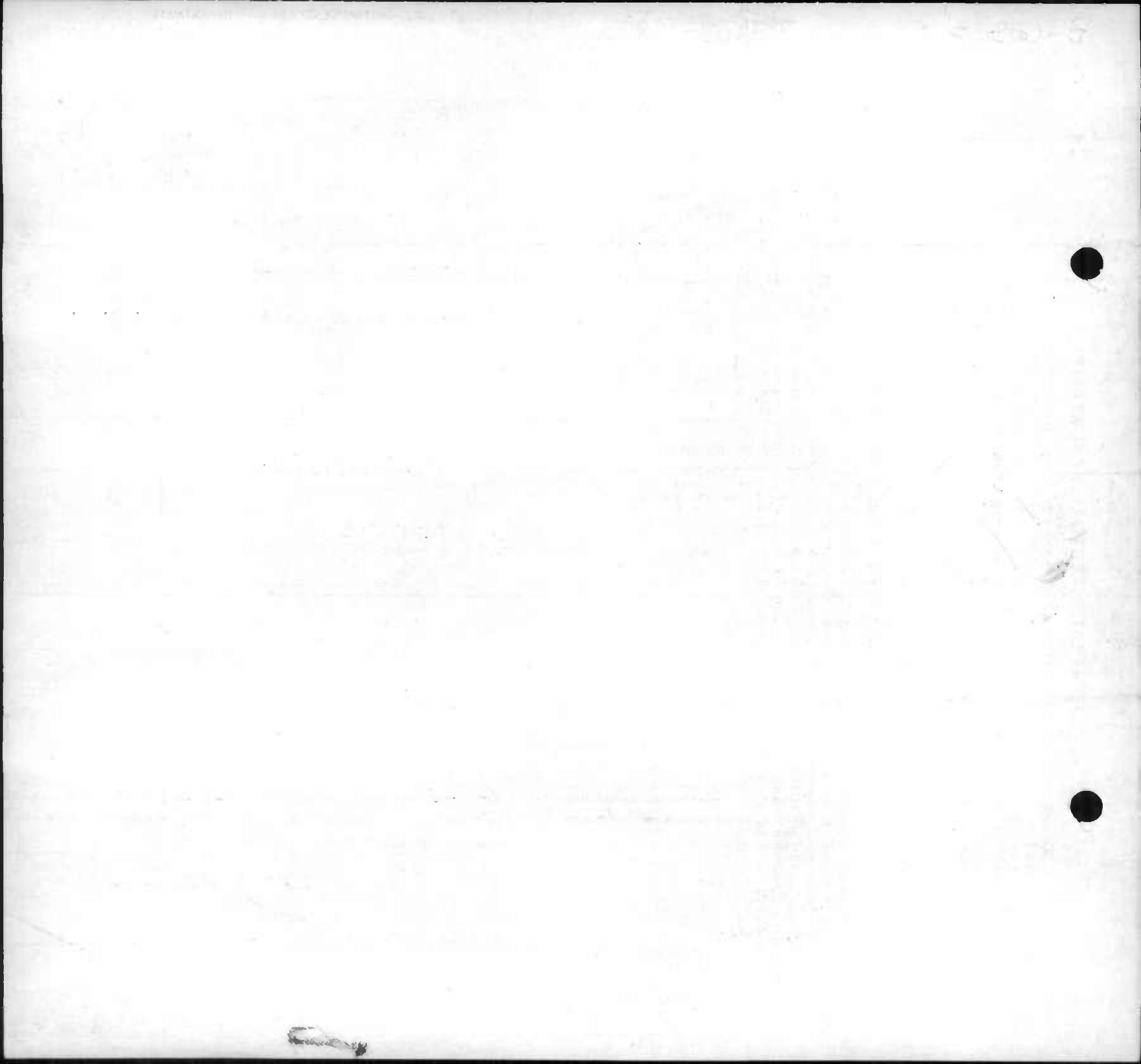
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3925

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3925

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Bryant, Beatrice</b>		2. DATE AND HOUR OF DEATH <b>4-11-68 3:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> <b>1514 Division Street</b> <b>Baltimore, Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2420 Madison Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-20</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>David Ruff</b>		14. MOTHER'S MAIDEN NAME <b>May Henson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>James Bryant</b> ADDRESS <b>2420 Madison Ave</b>	
18. <b>1829 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Malnutrition</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ca Uterus</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>174X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-10-68</b> 19 to <b>4-11-68</b> 19, that (I) (we) lost saw the deceased alive on <b>4-11-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE				23B. DATE SIGNED <b>4-11-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR KHAN</b> DEGREE				23D. ADDRESS <b>Provident Hospital</b> <b>1514 Division Street - Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>H-15-68</b>		24B. DATE <b>4-15-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Harford Co Md</b>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairburn</b>	
25C. FUNERAL DIRECTOR <b>Miss Frances A. Hensley</b>		25D. ADDRESS <b>W-Biddle</b>		25E. DATE OF DEATH <b>4-11-68</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-3926 CERTIFICATE OF DEATH

REG. NO. 68-3926

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Virginia Carolyn Michaels</i>		2. DATE AND HOUR OF DEATH <i>April 11, 1968 5:15 AM-M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University of Md. Hospital 20 Lombard St. Baltimore, Md. 21201</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
5. SEX <i>Female</i>		6. RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>2/5/37</i>		9. AGE (In years last birthday) <i>31</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Albert J. Michaels</i>	
14. MOTHER'S MAIDEN NAME <i>ARABELL Bartell</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-40-8009</i>	
17. INFORMANT <i>Albert J. Michaels</i>		ADDRESS <i>BALTO. 21218, MD.</i>		18. CAUSE OF DEATH <i>75391</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CHRONIC RENAL FAILURE</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PROB. CHRONIC PYELONEPHRITIS (CONG. RENAL ANOMALY)</i> <i>(B) DUE TO, OR AS A CONSEQUENCE OF:</i> <i>(C) DUE TO, OR AS A CONSEQUENCE OF:</i>	
19A. DATE OF OPERATION <i>757.3 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>9 March</i> 19 <i>68</i> to <i>11 April</i> 19 <i>68</i> , that (1) (we) last saw the deceased alive on <i>11 April</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>JEAN M. JACKSON M.D.</i>				23B. DATE SIGNED <i>11 April 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEAN M. JACKSON, M.D.</i>		23D. ADDRESS <i>Univ. Hosp. Bldg., Md. 21201</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-15-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>SACRED HEART CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>7401 GERMAN HILL RD. BALTO., CO., MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>	
25C. FUNERAL DIRECTOR <i>Charles J. Geller</i>		ADDRESS <i>9015 CONKLING ST. BALTO., 21224, MD.</i>			

HITE

H-323

68-3927

BALTIMORE CITY HEALTH DEPARTMENT

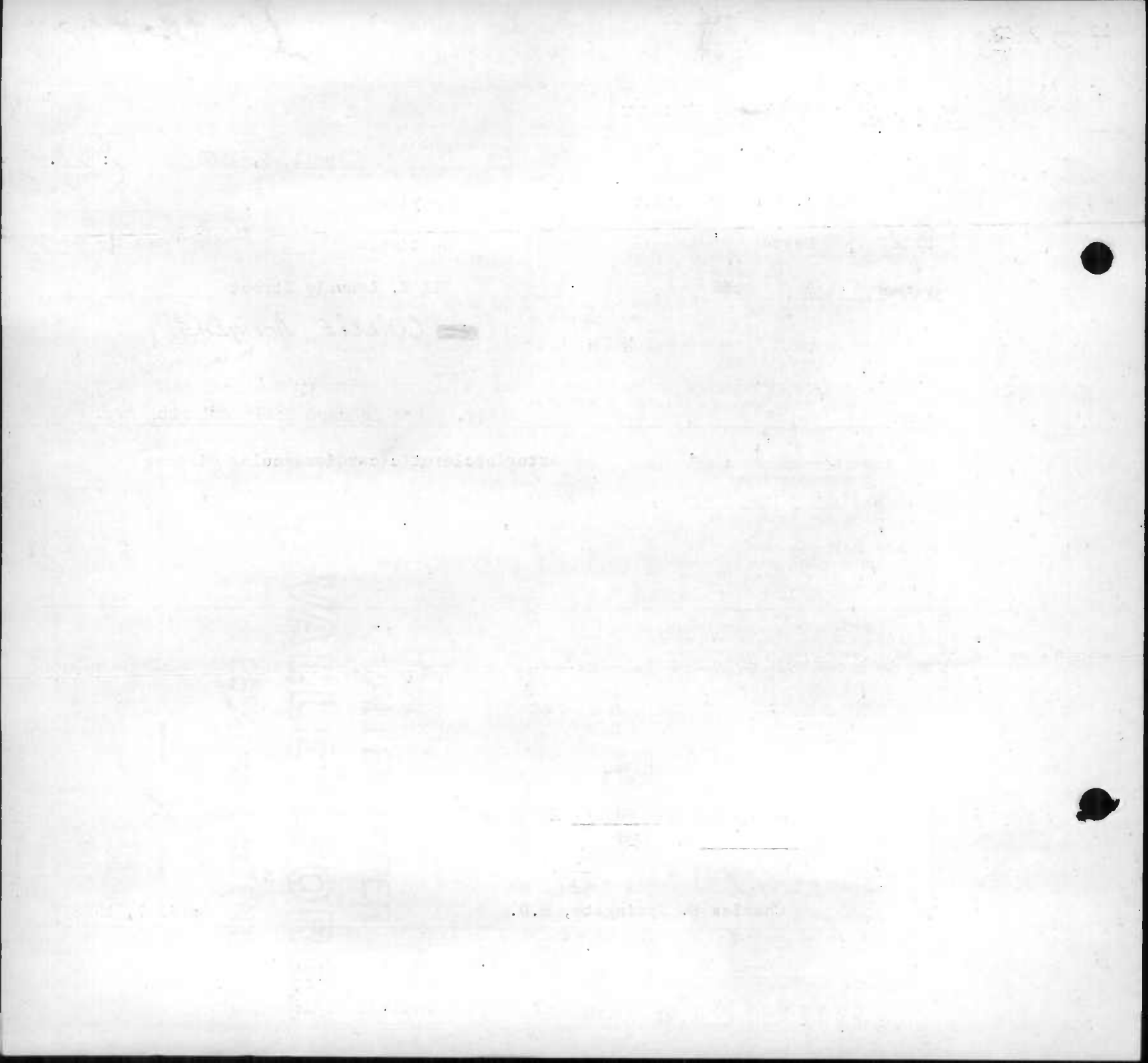
68-3927

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOUGLAS (FREDDIE) HATCHETT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>311 E. Lanvale Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 6, 1968 9:00 A.M.</b>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>NOV. 28, 1904</b>		10. AGE (In years lost birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Lucy</b>		18. INFORMANT ADDRESS <b>Mrs. Agnes Johnson 2817 Remington Ave.</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>722.1</b>			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 7, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>4-12-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber</b>	
25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		ADDRESS <b>1735 Harford Avenue</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3928	
68- 3928				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph A. North</i>		2. DATE AND HOUR OF DEATH <i>4-11-1968 11:15 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> # <i>21230</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		E. STREET AND NUMBER <i>1355 Jackson St.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-2-00</i>	9. AGE (In years lost birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Ship Yard</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>GEORGE B. North</i>		14. MOTHER'S MAIDEN NAME <i>Marceline Osban</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes # <i>1</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Evelyn Hickman 432 E. Randall St.</i>	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Tricuspid regurgitation</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Bronchogenic carcinoma</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bronchogenic carcinoma</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
162.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>4-8-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bronchoscopy &amp; biopsy</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>at</del> (this hospital) attended the deceased from <i>3-29</i> 19 <i>68</i> to <i>4-11</i> 19 <i>68</i> , that <del>it</del> (we) lost saw the deceased alive on <i>4-11</i> 19 <i>68</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>will</del> (did) (do not) view the body after death.					
23A. SIGNATURE <i>Richard H. Mack</i>				23B. DATE SIGNED <i>4-11-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard H. Mack</i>				23D. ADDRESS <i>1213 Light St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4 15 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>	
24D. LOCATION (City, town, or county) <i>Glen Burnie, A. A. Co. Md.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mc Cully 130 E. Fort Ave</i>	

George A. ...  
White ...  
2-2-00  
Marceline  
2-2-00

Richard H. ...  
1913 ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

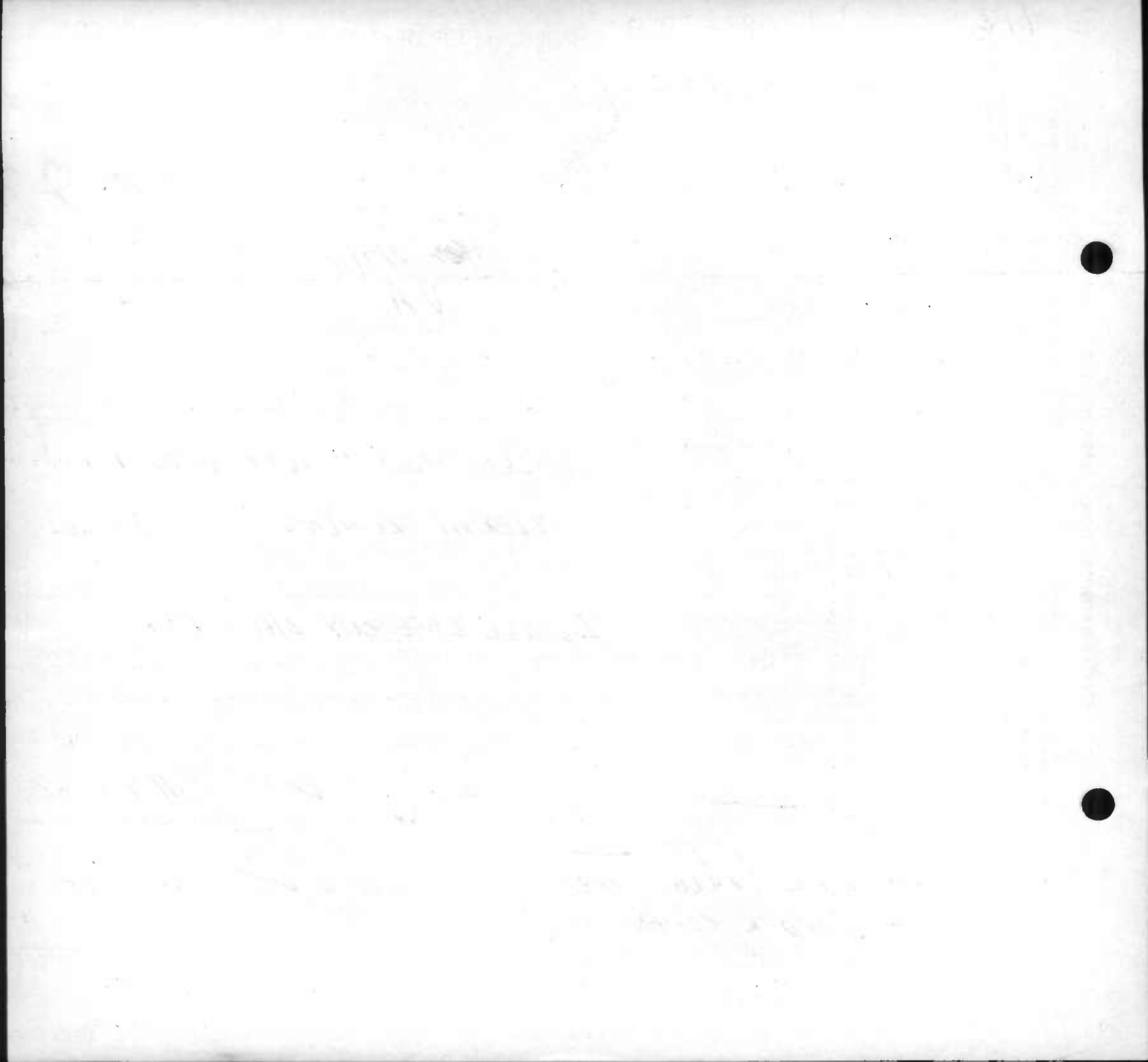
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3929
BIRTH NO. 68- 3929		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) EMMA STEWART COLLINS		2. DATE AND HOUR OF DEATH 4/10/68 4:10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1639 THOMAS AVE. BALTIMORE, MD.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY - C. CITY OR TOWN 1639 THOMAS AVE. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1639 THOMAS AVE		
5. SEX FEMALE	6. RACE COL.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/93	9. AGE (In years lost birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <del>MISSISSIPPI</del> MD.
13. FATHER'S NAME JOHN STEWART		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-30-7278		17. INFORMANT ADDRESS MARGARET HENDRICKS 4305 REISTERSTOWN RD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4/2/0 I HCUV, ASH D CUA-		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II		20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A		
19A. DATE OF OPERATION WAS PERFORMED N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJECTION (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> N/A		
21F. HOW DID INJURY OCCUR? N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A		
22. I certify that (I) (this hospital) attended the deceased from 3/10 1968 to 3/10 1968, that (I) (we) last saw the deceased alive on 3/10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE U. RAY JR.		23B. DATE SIGNED 4/11/68		
23C. PHYSICIAN'S NAME (Type) U. RAY JR., MD		23D. ADDRESS 2225 W North 21216		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/15/68		24C. NAME of CEMETERY or CREMATORY MT. AUBURN CEM.
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1968		
25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR ADDRESS MARGARETTA B. BROWN 3106 WABRUM AVE		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

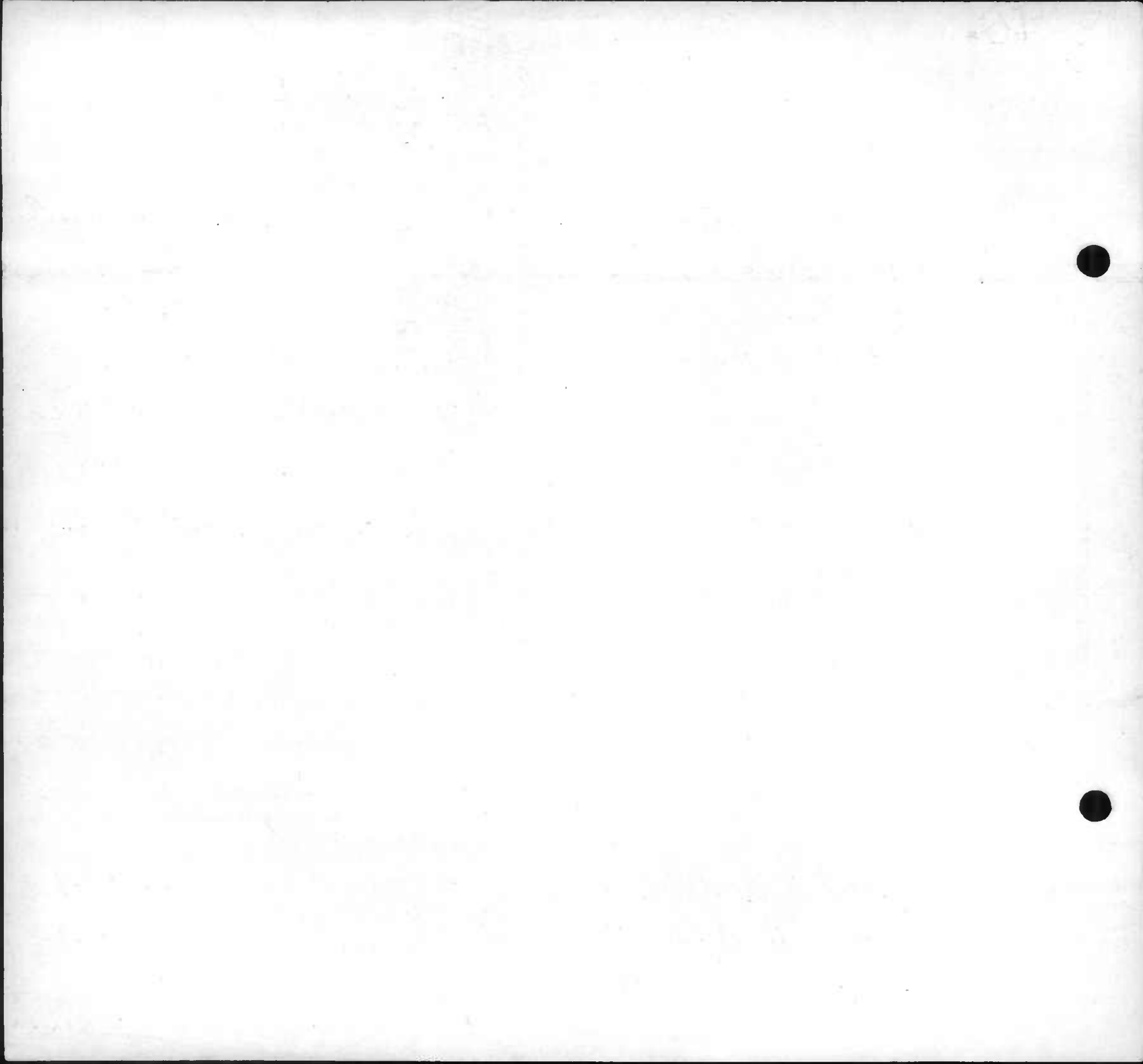
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3930</u>
68-3930		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <u>JOSEPH GILBERT</u>		2. DATE AND HOUR OF DEATH <u>4/9/68</u> <u>9:25 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP OF BALTO.</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/7/68</u>		9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>GEORGE W. GILBERT</u>		
14. MOTHER'S MAIDEN NAME <u>HARRIET POSTON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWI</u>		
16. SOCIAL SECURITY NO. <u>216-18-9463</u>		17. INFORMANT <u>MRS ROSE ANN GILBERT</u>		
18. <u>291.0 + 162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>HYPERPYREXIA (TEMP 107°)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>DELIRIUM TREMENS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>36 hrs</u>		
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>307X II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>LOWER LOBECTOMY 2/68 FOR CA.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/8/68</u> to <u>4/9/68</u> , that (I) (we) lost saw the deceased alive on <u>4/9/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Edward R. Cohen, MD</u>		23B. DATE SIGNED <u>4/9/68</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD R. COHEN, MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/13/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>LAKEVIEW MEMORIAL</u>
24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN MD</u>		25A. DATE REC'D BY HEALTH DEPT.		
25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME-422 BELAIR</u>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 3931
BIRTH NO. <i>Virginia</i>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>Luther E. Bell Sr.</i>		2. DATE AND HOUR OF DEATH <i>April 9/68 4 30 P M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN <i>Dundalk</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>B C H</i> <i>4900 Eastern Ave</i>		E. STREET AND NUMBER <i>102 Willow Springs Rd</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocer</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>FOOD</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>JAMES H. BELL</i>		14. MOTHER'S MAIDEN NAME <i>Lannie Swain</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>LUTHER J. BELL 102 WILLOW SPRING</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary occlusion</i> (B) <i>arteriosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>8 years.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Jan 1</i> 19 <i>48</i> to <i>Apr 9</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 29</i> , 19 <i>68</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>David H. Andrew M.D.</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/10/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>David H. Andrew M.D.</i>		23D. ADDRESS <i>322 Kernway Baltimore MD 21212</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/12/68</i>		24C. NAME of CEMETERY or CREMATORY <i>OAK LAWN</i>	
24D. LOCATION (City, town, or county) (State) <i>COLGATE MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i>		25C. FUNERAL DIRECTOR <i>ULLICH FUNERAL HOME DUNDALK MD</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3932 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-3932

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>John Grudzinsky (Grudzinski)</b>		2. DATE AND HOUR OF DEATH <b>11 April 1968 4:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHN</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2225 Essex St</b>					
5. SEX <b>M</b>	6. RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-90</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Europe Lithuania</b>	
13. FATHER'S NAME <b>IGNATIUS GRUDZINSKY</b>		14. MOTHER'S MAIDEN NAME <b>Bogumila UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-05-6628</b>		17. INFORMANT <b>Mrs. Helen Baclaski, 2225 Essex Street</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the injury or complication which caused death.) <b>230.7 I</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>A. S. Vascular Disease</b> (B) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>260X II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-31</b> 19 <b>68</b> to <b>4-11</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ephraim Barzaga</b>				23B. DATE SIGNED <b>4-11-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ephraim BARZAGA</b>		23D. ADDRESS <b>CHURCH Home &amp; Hosp. Inc. BALD. 31</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/15/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town or village) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farley, Jr.</b>		25C. FUNERAL DIRECTOR <b>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>			

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BOTWRIGHT, OLIVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-362

68- 3933

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3933

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BOTWRIGHT, Olive W.		4/12/68 8:50 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland Baltimore		A. STATE B. COUNTY	
The Johns Hopkins Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore Essex		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		408 N. Marlyn Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birth day)	10. Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7/12/92	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Hawkrun, Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Strohm		Jennie Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Dahlgren Funeral Home, Philipsburg, Penna.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Pulmonary Edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia (B) Post-Op Complications 8 days DUE TO, OR AS A CONSEQUENCE OF: (C) Surgery for Empyema gall-bladder OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): ① H/O 2 previous M.I.s ② Emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/6/68		Empyema Gall-bladder		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				No	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/4/68 to 4/12/68 and that (I) (we) last saw the deceased alive on 4/12/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Robert D. Pipkin				4/12/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Robert D. Pipkin				Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-16-1968		Philipsburg Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 15 1968		Robert E. Tarkenton		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3934
BIRTH NO.				68- 3934
1. NAME OF DECEASED (Type or Print) <b>Emma Lee Burkett</b>		2. DATE AND HOUR OF DEATH <b>4/8/68 12:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>6009 Prescott Ave.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b>		6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/1879</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		9. AGE (In years last birthday) <b>88</b>
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Randal Lee</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Banks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>TRESA BURKETT - 6009 Prescott Ave</b>
18. <b>4/2, 0 1</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Hypertensive Cardiovascular Heart Disease - Failure</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized Arteriosclerosis</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>443X II</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Thyroid Adenoma Benign</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 1952</b> to <b>8 April 1968</b> that (I) (we) last saw the deceased alive on <b>2 April 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Lauriston L. Keown M.D.</b>				23B. DATE SIGNED <b>8 April 68</b>
23C. PHYSICIAN'S NAME (Type) <b>LAURISTON L. KEOWN M.D.</b>		23D. ADDRESS <b>431 EAST LAKE AVE BALTIMORE, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt. calvary</b>
24D. LOCATION (City, town, or county) (State) <b>Brooklyn D. D. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Wm. L. Whitcomb - 1701 Wm. Cullough</b>		

8 April 1958

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-3935				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3935	
1. NAME OF DECEASED (Type or Print) <u>Carol Jean Jane</u>				2. DATE AND HOUR OF DEATH <u>4-11-68</u> <u>10<sup>45</sup> A. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>BON SECOURS HOSPITAL 4268</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Catonsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>449 WHITFIELD RD.</u> <u>53-00</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-68</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH J. HENNEQUIN, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Jane Warren</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. HENNEQUIN, Jr.</u> ADDRESS <u>449 Whitfield Rd.</u>	
18. <u>425X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>? Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immature infant 925 gm</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-12-68</u> to <u>4-11-68</u> , that (I) (we) last saw the deceased alive on <u>4-12-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. A. Melcoton</u>				23B. DATE SIGNED <u>4-10-68</u>		23C. PHYSICIAN'S NAME (Type) <u>A.A. MELCOTON</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4-13-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>CAPEVILLE MASONIC EM.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u> ADDRESS <u>4107 WILKENS AVE. BALTO. MD. 21229</u>	

5/2/68 - Correction form from funeral director.

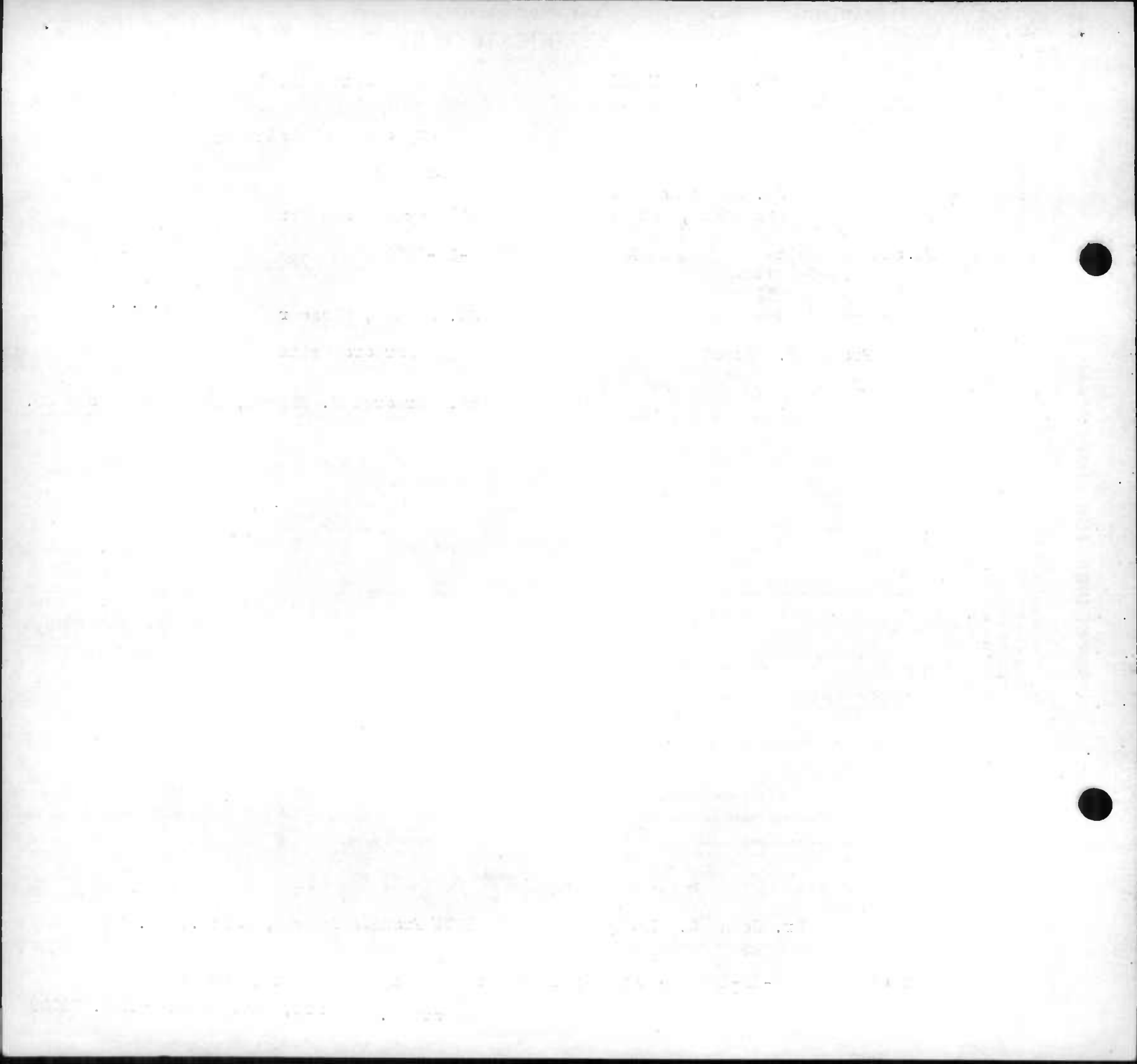
*Age.*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-3936

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY M. TRAPP</b>		2. DATE AND HOUR OF DEATH <b>April 11, 1968</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>St. Agnes Hospital Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Arbutus</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1230 Seven Oaks Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1889</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Joseph, Missouri</b>	
13. FATHER'S NAME <b>Frank K. Stock</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Deitz</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Margaret R. Kissel, 1230 Seven Oaks Rd.</b>	
18. <b>412.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>443X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>terminal Cardiac Failure</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1954</b> to <b>4/11/1968</b> , that (I) (we) lost saw the deceased alive on <b>4/7/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John C. Healy</b>				23B. DATE SIGNED <b>4/12/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. John C. Healy</b>		23D. ADDRESS <b>1311 Francis Avenue, Balto., Md. 21227</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-15-1968</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Farkema</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3937 CITY HEALTH DEPARTMENT  
68-3937 CERTIFICATE OF DEATH

REG. NO. 68-3937

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CRONIN, PATRICIA K.</b>		2. DATE AND HOUR OF DEATH <b>APRIL 12, 1968 6:20A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>11-18-23</b>		9. AGE (In years lost birthday) <b>44</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Thomas E. Kyne</b>			14. MOTHER'S MAIDEN NAME <b>Mary A. Hellbach</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-20-1317</b>		17. INFORMANT <b>CATON &amp; WILKENS AVES ST. AGNES RECORDS-BALTO., MD. 21229</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>LAENNOIS CIRRHOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY EDEMA - BILATERAL</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>5-8-1-1 II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>MARCH 27 19 68</b> to <b>APRIL 12 19 68</b> , that (X) (we) last saw the deceased alive on <b>APRIL 12 19 68</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (and not) view the body after death.					
23A. SIGNATURE <i>R Revilla</i>				23B. DATE SIGNED <b>04 12 68</b>	
23C. PHYSICIAN'S NAME (Type) <b>R REVILLA</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVES.-BALTO., MD 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-15-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

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Page 2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 3928 CERTIFICATE OF DEATH

REG. NO. 68- 3938

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PAGEL, LEWIS H, Jr.</b>		2. DATE AND HOUR OF DEATH <b>APRIL 12 1968 9:45 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>LUTHERAN HOSPITAL OF MD.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MD.</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>5407 CHANNING RD. 53-00</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-24-1923</b>	9. AGE (In years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Driver</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Lewis H. Pagel, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Sallie Morgan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-16-6974</b>		17. INFORMANT <b>Mrs. Mary J. Pagel</b> <b>5407 Channing Rd. 21229</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION - HOURS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <b>NO</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED <b>4/12/68</b>		21H. DATE SIGNED <b>4/12/68</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> 19 <b>68</b> to <b>4/12</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/12/68</b> 19 <b>68</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Renato R. Espina</b>			23B. ADDRESS <b>21 S. St. Johns Lane, E.C.</b>		
23C. PHYSICIAN'S NAME (Type) <b>RENATO R. ESPINA</b>			23D. ADDRESS <b>21 S. St. Johns Lane, E.C.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>	
24D. LOCATION (City, town, or county) <b>md.</b>		24E. STATE <b>md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>

1-105-57



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3939

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3939

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET E. ROGERS

2. DATE AND HOUR OF DEATH

APRIL 11, 1968 7:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

19 HARRISON AVE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

JULY 8, 1885

9. AGE (In years last birthday)

82

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

UNEMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

FRANK BACKERT

14. MOTHER'S MAIDEN NAME

ANNA DOTTEWICH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

WINFIELD ROGERS 1426 ROSEWICK AVE

18. 25071

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE

(B) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:

(C) DIABETES MELLITUS

260X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

PNEUMONIA

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 8 1968 to April 11 1968, that (I) (we) lost saw the deceased alive on April 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Francisco Baltazar, Jr. MD

MD DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

April 11, 1968

23C. PHYSICIAN'S NAME (Type)

FRANCISCO BALTAZAR, JR. MD

MD DEGREE

23D. ADDRESS

Church Home Hospital 100 N. Broadway, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/15/68

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE

MARYLAND

2411 HARRISON AVE

22 JULY 1882

MARYLAND

2411 HARRISON AVE

CONGRESSIONAL DISTRICT

WATERGATE & HARRISON

DIABETES MELLITUS

THEODORE

1111 HARRISON AVE

FRANK WHITE

FRANK WHITE

FRANK WHITE

K-260

68- 3940

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 68- 3940

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JACOB

KAISER

(Jacob Kaiser)

2. DATE AND HOUR OF DEATH

4/13/68

5:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

48 MARYLAND

GENERAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1552 Winford Rd

5. SEX

Male

6. RACE

Cauc

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5/3/98

9. AGE (In years  
last birthday)

69

If Under 1 Yr.

Months: Days: Hours: Min.

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-

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

UNKNOWN

Machinist

Machine Shop

11. BIRTHPLACE (State or foreign country)

HUNGARY

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

FERDINAND

KAISER

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-01-8539

17. INFORMANT

Michael Kaiser

ADDRESS

1552 Winford

18. 412.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(generalized)

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY

(Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~he~~ (this hospital) attended the deceased from 4/11 1968 to 4/13 1968.  
that ~~he~~ (we) last saw the deceased alive on 4/12 1968 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. E. DeFelice

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-13-68

23C. PHYSICIAN'S  
NAME (Type)

C. E. DeFelice

DEGREE

23D. ADDRESS

Md. General Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/16/1968

24C. NAME OF CEMETERY OR CREMATORY

Gardens Of Faith Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Faulkner

25C. FUNERAL DIRECTOR

Jimmie Funeral Home

4611 Park Heights

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Section 2

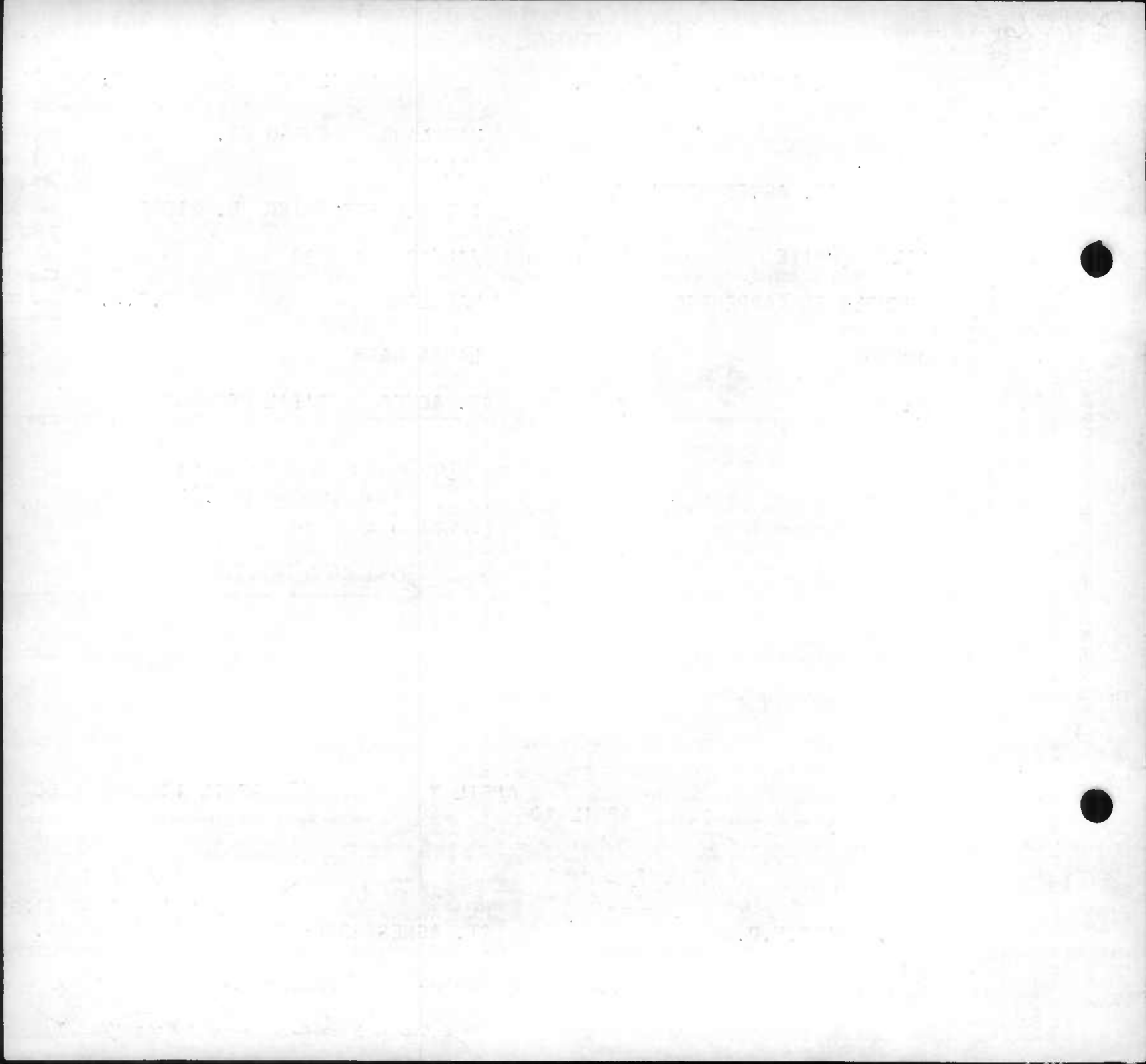
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Section 2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3941	
1. NAME OF DECEASED (Type or Print)		PALMER, KENNETH H.		2. DATE AND HOUR OF DEATH APRIL 10, 1968 1:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND HOWARD CO. 63-00			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN ELLCOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 107 OLD FREDERICK RD. 21043			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/29	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JUDSON		14. MOTHER'S MAIDEN NAME LAURA HARR		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 7		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive encephalopathy and pericarditis (B) DUE TO, OR AS A CONSEQUENCE OF: Uremia (C) Chronic Glomerulonephritis			
19A. DATE OF OPERATION 5-9-2 X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 68 to APRIL 10 19 68, that (I) (we) lost saw the deceased alive on APRIL 10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. Weiss</i>				23B. DATE SIGNED 04/10/68	
23C. PHYSICIAN'S NAME (Type) E. WEISS, M.D.		23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-68		24C. NAME OF CEMETERY or CREMATORY Good Shepherd ELLCOTT CITY MD	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR John R. Black ELLCOTT CITY, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3942

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3942

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>ANNA K. SPIEL</i>		2. DATE AND HOUR OF DEATH <i>8:10 PM 4-9-68</i>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BEN SECCAS HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>ELICOTT CITY, HOWARD COUNTY</i>			
				C. CITY OR TOWN <i>ELICOTT CITY</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>12 HUNT AVE.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-16-87</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>SWITZERLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>CHRISTIAN BECK</i>				14. MOTHER'S MAIDEN NAME <i>KATHERINE HORMANN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Geo. L. Spiel Sr. Husband</i>		ADDRESS <i>SAME</i>	
18. <i>412.9 Y-5887</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>422.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <i>4-8-1968</i>				CAUSE OF DEATH IMMEDIATE CAUSE <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>  <i>years</i>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture, right hip</i>				20A. AUTOPSY (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NURSING HOME</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Summit Nursing Home</i>			
21D. TIME OF INJURY (APPROX.) <i>4-4-68</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Fell while trying to walk</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>4-5-1968</i> to <i>4-9-1968</i> , that (I) (we) last saw the deceased alive on <i>4-9-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Octavio A. Ruiz M.D.</i>				DEGREE		23B. DATE/SIGNED <i>4/9/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Octavio A. Ruiz M.D.</i>				DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-13-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>LORELAINE PARK</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John R. Hall</i>		ADDRESS <i>ELICOTT CITY, MD.</i>	

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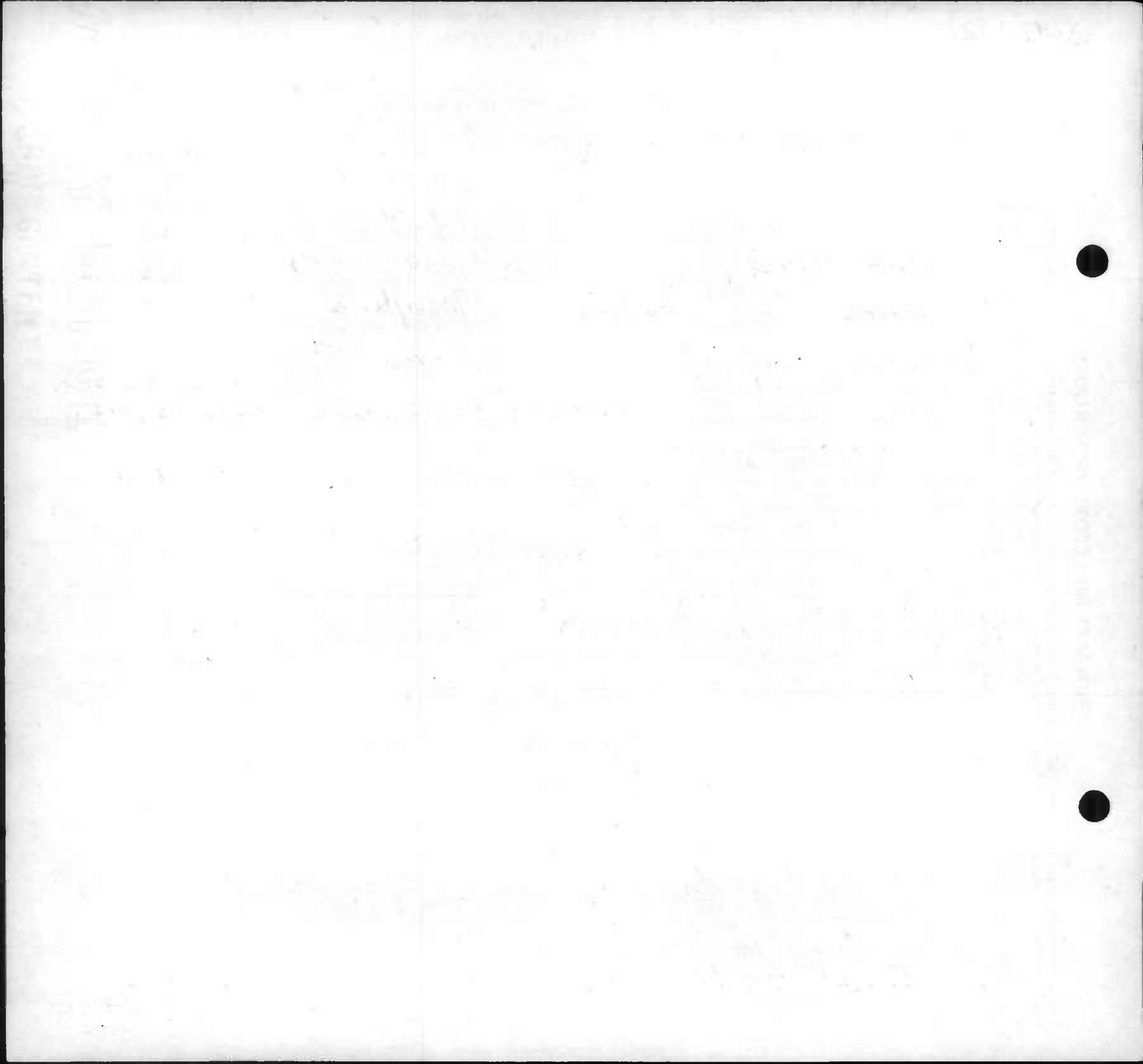
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3943

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3943

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Theodore Jarvis</u>		2. DATE AND HOUR OF DEATH <u>3-30-68</u> <u>9:45</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sumner Hospital Baltimore</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1118 W 38th Street</u>				F. ZIP CODE <u>21207</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-2-08</u>	9. AGE (In years last birthday) <u>59</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboe</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboe</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>JOEL JARVIS</u>		
14. MOTHER'S MAIDEN NAME <u>Nancy Thomas</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		
16. SOCIAL SECURITY NO. <u>216-10-6064</u>			17. INFORMANT <u>BRUCE JARVIS</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Intestinal Malignancy</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>199.2 II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3-27-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Diagnose Loe</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> 19 <u>68</u> to <u>3-30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Paul Kretzman M.D.</u>				23B. DATE SIGNED <u>3-30-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Paul Kretzman M.D.</u>				23D. ADDRESS <u>Sumner Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-4-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. STATE <u>MD.</u>		24F. ZIP CODE <u>21207</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1968</u>		25B. NAME OF REGISTRAR <u>Paul E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Higginbotham Slack</u>	
25D. ADDRESS <u>Ellicott St.</u>		25E. CITY <u>MD.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3944		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3944	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LINTON, James Leroy</b>		2. DATE AND HOUR OF DEATH <b>3-30-68 9:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b>		C. CITY OR TOWN <b>Catonsville</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		E. STREET AND NUMBER <b>828 Frederick Road</b>		53-00	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-21-12</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Psychiatric Aide</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Sykesville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Leonard I. Linton</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle B. Touey</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 6-15-42 to 12-20-45</b>		16. SOCIAL SECURITY NO. <b>216-03-09-92</b>		17. INFORMANT <b>VA Hospital Records</b> ADDRESS <b>3900 Loch Raven Blvd, Baltimore, Md 21218</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Extensive Infraction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Mural Thrombi, right Appendage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Hypertrophy</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>420.1 II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pulm Emboli and Pulm Emphysema</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>13 March 19 68</b> to <b>30 March 19 68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>30 March 19 68</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>view</b> the body after death.			
23A. SIGNATURE <b>ESMAEL ANGULO, MD</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ESMAEL ANGULO, MD</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>1 APR 15 1968</b>	
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Higinbottom Slack</b>		ADDRESS <b>Ellicott City, Md.</b>	

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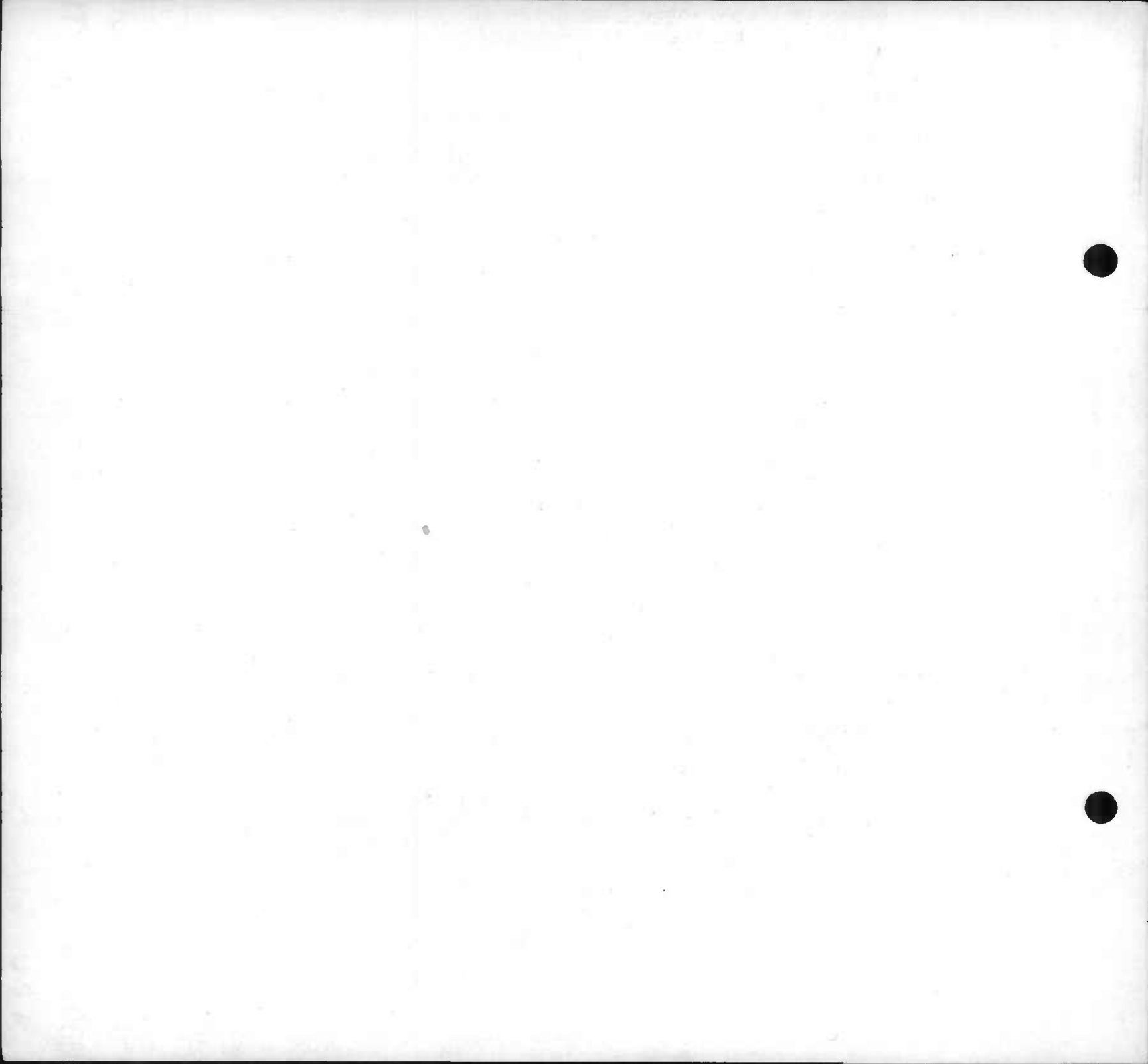
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68-3945 CERTIFICATE OF DEATH

REG. NO. 68-3945

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lavinia Magaha</i>		2. DATE AND HOUR OF DEATH <i>4-10-68</i> <i>2:30 A</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		5. SEX <i>F</i> 6. RACE <i>W</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3510 Chestnut Ave</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-30-88</i> 9. AGE (In years last birthday) <i>79</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>		16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Records - Bolton Hill Nursing Home</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Pneumonia</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>= 4 days</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <i>Diabetes Mellitus</i>		<i>?</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Chronic Renal Disease</i>		<i>?</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-8-68</i> 19 <i>68</i> to <i>4-10</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-10</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>William L. Boddie M.D.</i>		23B. DATE SIGNED <i>4-10-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>William L. Boddie M.D.</i>		23D. ADDRESS <i>Maryland General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/12/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>LOIRRAINE PARK</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO., CO.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, Jr.</i>	
25C. FUNERAL DIRECTOR <i>Paul E. Charney</i>		ADDRESS <i>3617 Chestnut Ave</i>			



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68- 3946 BALTIMORE CITY HEALTH DEPARTMENT

68- 3946

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANTHONY MAVROGIANNIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 8, 1968</b> Hour: <b>1:20 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year <b>April 8, 1968</b> Hour: <b>1:40 P.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>April, 1900</b>		10. AGE (in years last birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>Greece</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-05</b>	
15. MOTHER'S MAIDEN NAME <b>Mary</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>168-10-7358A</b>		18. INFORMANT <b>Nancy Mavrogiannis</b> ADDRESS <b>701 S. Umbra St., Baltimore, Md.</b>	
19. CAUSE OF DEATH <b>412.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/9/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-11-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Greek Orthodox Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>	
25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>	



## 68-- 3947 CERTIFICATE OF DEATH

REG. NO. 68-- 3947

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Michael Hollias

2. DATE AND HOUR OF DEATH

4-9-1968

5.00 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

524 South Quail Street

21224

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-15-1893

9. AGE (In years  
last birthday)

75

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Hot Strip

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF WHAT COUNTRY?

Greece

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Irene

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-07-2327

17. INFORMANT

Records: BCH-4940 Eastern Avenue

ADDRESS

21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:Metastatic CA from  
Rectum.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐  
WorkNot White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-23-19 68 to 4-9-19 68,  
that (I) (we) lost saw the deceased alive on 4-9-19 68 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dowd J. Yarborough M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-9-1968

23C. PHYSICIAN'S  
NAME (Type)

DOWD J. YARBOROUGH

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue, Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-12-68

24C. NAME OF CEMETERY OR CREMATORY

Greek Orthodox Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Ruben E. Farley

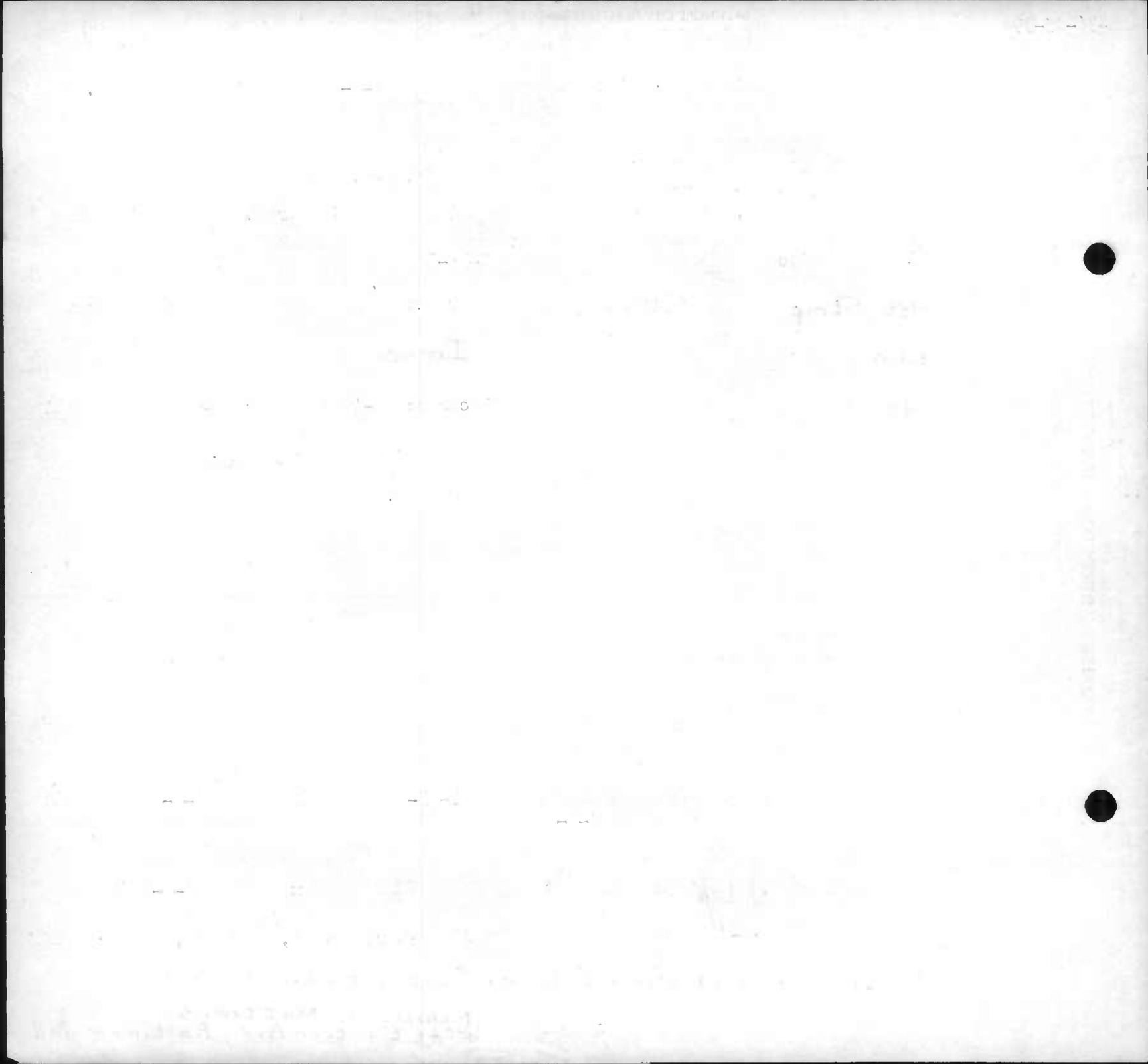
25C. FUNERAL DIRECTOR

Nicholas T. Matthews  
3021 Eastern Ave., Baltimore, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3948

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3948

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Stanley L. Day</b>		2. DATE AND HOUR OF DEATH <b>4/10/68</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Mem. Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2/5/09</b>		9. AGE (In years last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>?</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-2609</b>	
17. INFORMANT <b>Stanley N. Day</b>		ADDRESS <b>4 Wild Cherry Ct.</b>		18. <b>412.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Hepatic disease</b>	
19. DATE OF OPERATION <b>443X II</b>		20. AUTOPSY? (Yes or No) <b>No</b>		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Muscular system</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4/6</b> 19 <b>68</b> to <b>4/6</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <b>Edward O. Hallen</b>		24. DATE SIGNED <b>4/12/68</b>	
25. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		26. NAME OF REGISTRAR <b>Paul E. Chenoweth</b>		27. FUNERAL DIRECTOR <b>Paul E. Chenoweth</b>	
28. DATE <b>4/13/68</b>		29. NAME OF CEMETERY or CREMATORY <b>Lorraine Park</b>		30. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>	
31. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		32. NAME OF REGISTRAR <b>Paul E. Chenoweth</b>		33. FUNERAL DIRECTOR <b>Paul E. Chenoweth</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3949

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3949

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILDRED S. HOKE

2. DATE AND HOUR OF DEATH

April 10, 1968 7:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

508 Drury Lane  
Baltimore, Maryland 21229

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒ NO ☐

E. STREET AND NUMBER

508 Drury Lane

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9-26-1895

9. AGE (In years last birthday)

72

10. Under 1 Yr. Months: Days:

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Grant Schuck

14. MOTHER'S MAIDEN NAME

Della (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
213-28-4031

17. INFORMANT

ADDRESS

Mr. William A. Hoke, 517 Overdale Rd. 21229

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinoma of Lung, Metastatic  
DUE TO, OR AS A CONSEQUENCE OF:

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Carcinoma of kidney, left  
DUE TO, OR AS A CONSEQUENCE OF:

2 yrs.

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (We) attended the deceased from June 1951 to April 1968, that (I) (We) last saw the deceased alive on April 9 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Leo Gaver M.D.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

April 12, 1968

23C. PHYSICIAN'S NAME (Type)

Dr. Leo Gaver

23D. ADDRESS

1 Mallow Hill Road, Balto., Md. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-13-1968

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Woodlawn, Baltimore County, Md.

25A. DATE RECEIVED BY HEALTH DEPT.

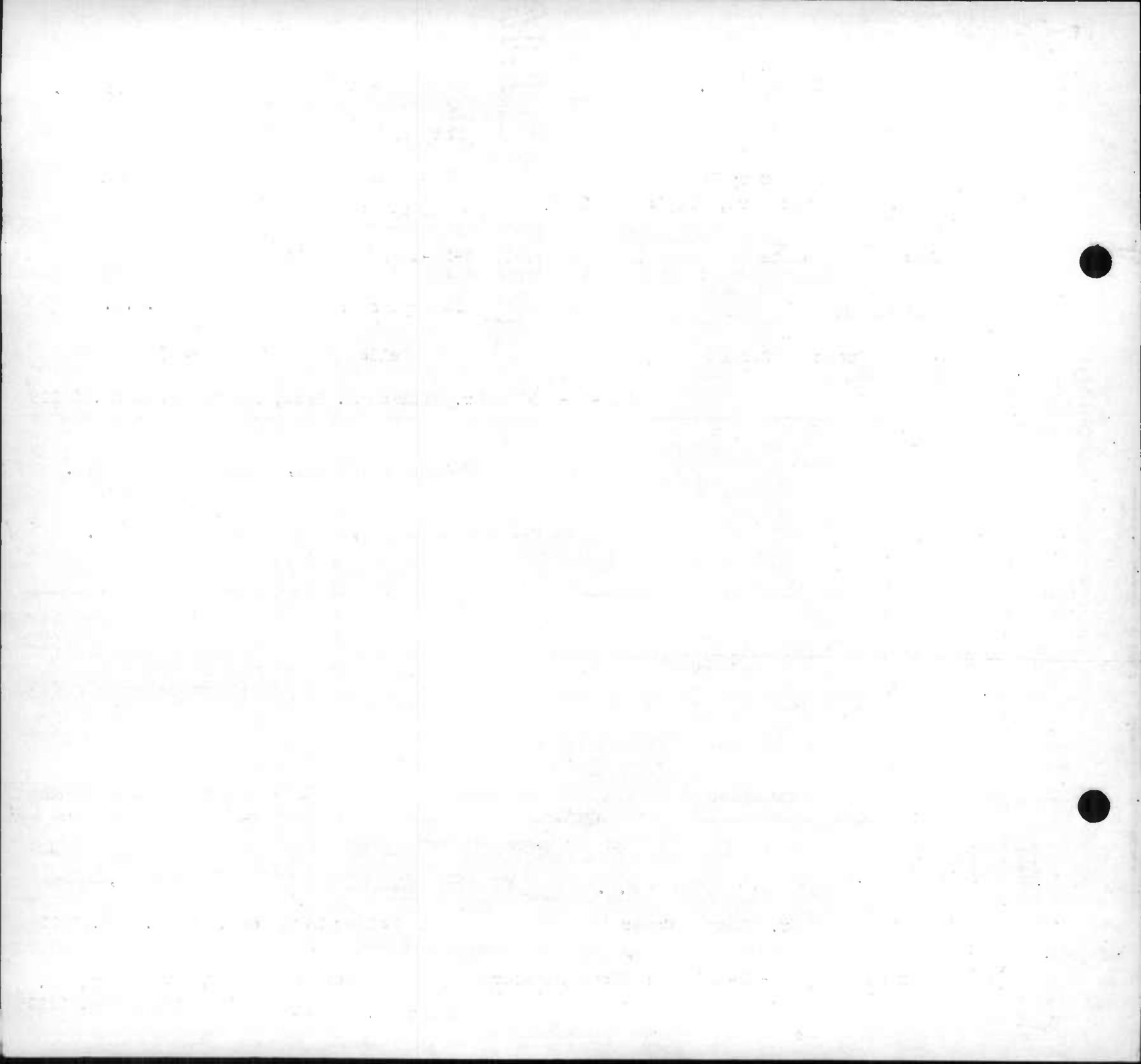
APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Ave. 21229



T-553

68- 3950

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3950

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Byron D. Tennant

2. DATE AND HOUR OF DEATH

4/5/68

6:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Maryland # 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

63-00

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Matthews Ave. # 21222 005

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4-18-85

9. AGE (In years last birthday)

82

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Bryon Tennant dec.

14. MOTHER'S MAIDEN NAME

Effie Trusdale dec.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL SECURITY NO.

212-07-7425

17. INFORMANT

ADDRESS

BCH: Records 4940 Eastern Ave. Baltimore, Md. # 21224

18. 4-12-91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE ASCVD - CABS  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-31 19 68 to 4-5- 19 68, that (I) (we) lost saw the deceased alive on 4-5- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ld Lippman

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

4/5/68

23C. PHYSICIAN'S NAME (Type)

Leonard Lippman, MD

DEGREE

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/17/68

24C. NAME of CEMETERY or CREMATORY

OAK LAWN

24D. LOCATION

BALTO. MD.

25A. DATE RECD BY HEALTH DEPT.

25B. NAME OF REGISTRAR

Phyllis E. Taylor

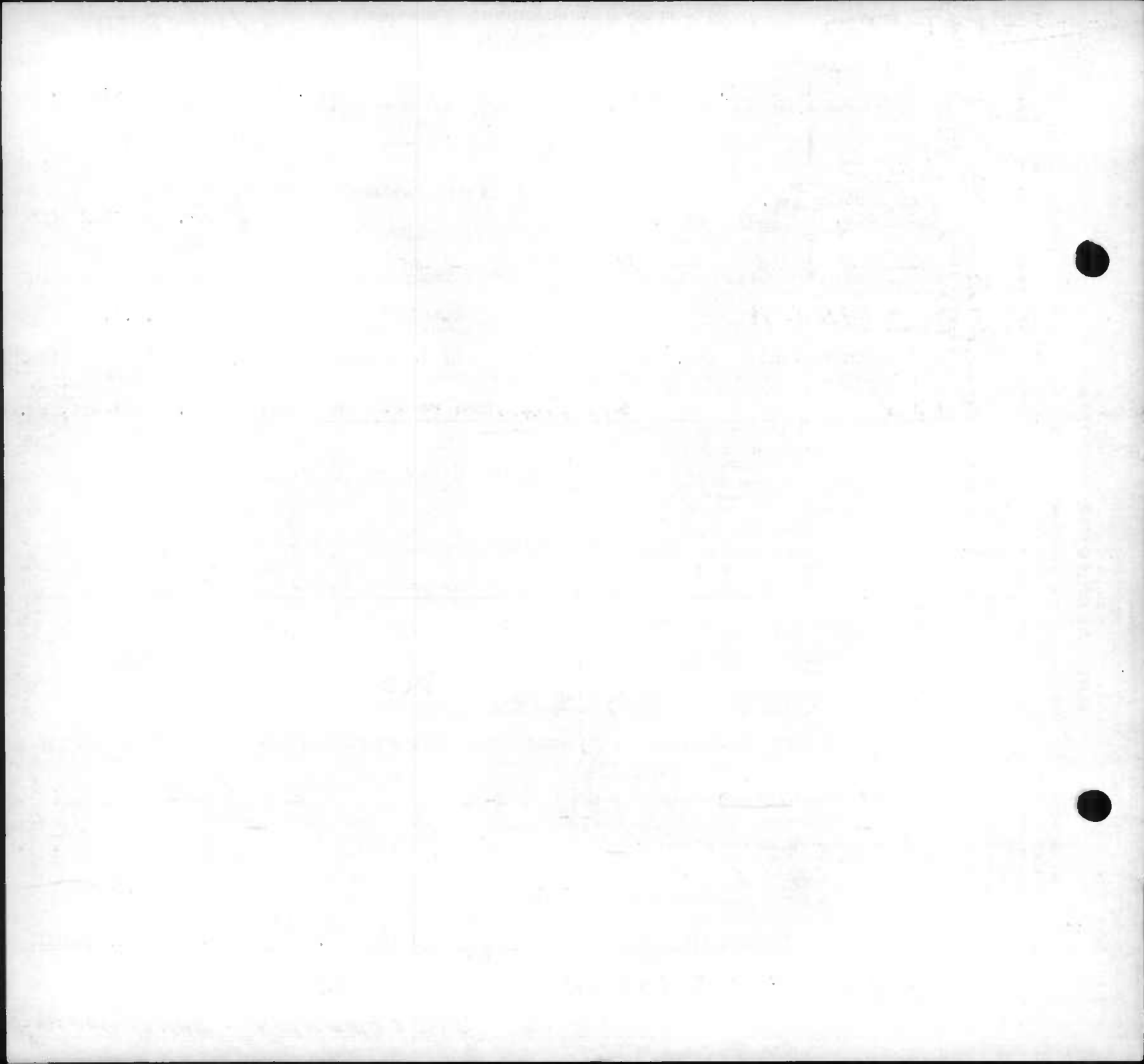
25C. FUNERAL DIRECTOR

J.G. CONNELLY SONS 300 MACE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1  
C-455

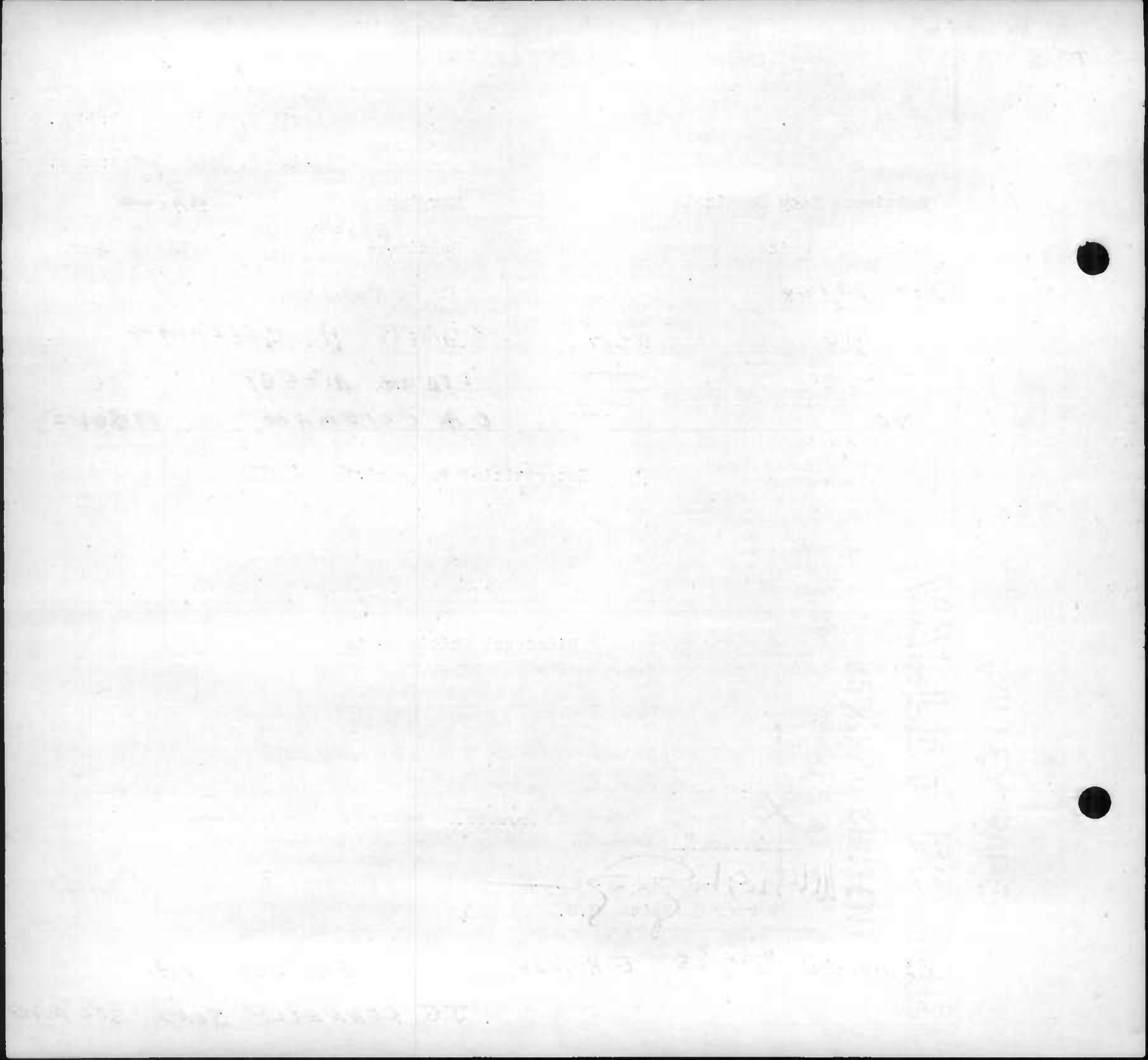
68- 3951 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3951

BIRTH NO. 68-1668

1. NAME OF DECEASED (Type or Print) ODNER W. COLEMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> April 8, 1968 Hour: 2:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour April 8, 1968 9:05 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO	
9. DATE OF BIRTH JAN 27 1968		10. AGE (In years lost birthday) 2 12	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT O.A. COLEMAN		ADDRESS ABOVE	
19. 484X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL PNEUMONITIS (SDII) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral Otitis Media	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/9/68	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 4/10/68	
24C. NAME OF CEMETERY or CREMATORY GRUNDY		24D. LOCATION (City, town, or county) (State) GRUNDY VA.	
25A. DATE RECEIVED BY HEALTH DEPT. APR 10 1968		25B. NAME OF REGISTRAR Robert E. Talley, Jr.	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3952

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3952

BIRTH NO.

1. NAME OF DECEASED

(Type as Print)

NETTIE BENSTEAD

2. DATE AND HOUR OF DEATH

April 12, 1968

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ANDERSON NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3306 Liberty Hghts. Avenue

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

6-15-1877

9. AGE (In years last birthday)

90

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Henry Hoover

14. MOTHER'S MAIDEN NAME

Michael

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Margaret Keithley-1414 Philadelphia Rd.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Joppa, Maryland

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1966 to April 11, 1968, that (I) (we) lost saw the deceased alive on April 11, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

Thomas G. Abbot

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4-13-68

23D. ADDRESS

4509 Liberty Hghts. Ave

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-15-68

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. F. Adams

25C. FUNERAL DIRECTOR

Ellsworth Armacost Funeral Chapel

ADDRESS

4600 Liberty Hghts. Avenue

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-560		68- 3953		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 3953	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Banner, Joseph</i>				4/13/68 10:55 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				A. STATE <i>Maryland</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>5106 Belleville Avenue</i>		<i>21207</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-16-1889</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman - Telephone Co.</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jacob Banner</i>			14. MOTHER'S MAIDEN NAME <i>Claudia Raffensberger</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>212-10-0921A</i>		17. INFORMANT <i>Edna C. Banner-5106 Belleville Avenue</i> <i>Records: BCH-4940 Eastern Avenue</i> <i>21224</i>		
18. <i>207.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Unknown</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. DATE OF OPERATION <i>7955-11</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Leukemia</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>2/12</i> 19 <i>68</i> to <i>4/13</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/13</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Mary Ann Sullivan M.D.</i>				23B. DATE SIGNED <i>4/13/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Mary Ann Sullivan</i>	
23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Baltimore, Maryland 21224</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-17-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairburn</i>		25C. FUNERAL DIRECTOR <i>Ellsworth Armacost-4600 Liberty Hights. Ave</i>		ADDRESS	

1115

177 188 111

[illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3954

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3954

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PAULINE BOONE

2. DATE AND HOUR OF DEATH

4-13-68 5:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 MARYLAND GENERAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

433 W. Biddle St.

5. SEX

Female

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

7-18-06

9. AGE (In years last birthday)

61

If Under 1 Yr. Months: Days:

- - -

If Under 24 Hrs. Hours: Min.

- - -

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Will Jefferson

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Nellie Dossy

ADDRESS

1501 Hillen

18. 436.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Edema

Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Vascular Accident

2 wks

(C) DUE TO, OR AS A CONSEQUENCE OF:

Hypertension

Years

331X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

-

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)

-

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

-

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

-

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

-

22. I certify that (X) (this hospital) attended the deceased from 4/12 1968 to 4/13 1968, that (I) (we) last saw the deceased alive on 4/12 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

C. E. DeFelice

DEGREE

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

4-13-68

23C. PHYSICIAN'S NAME (Type)

C. E. DeFelice

DEGREE

23D. ADDRESS

Md. General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-17-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

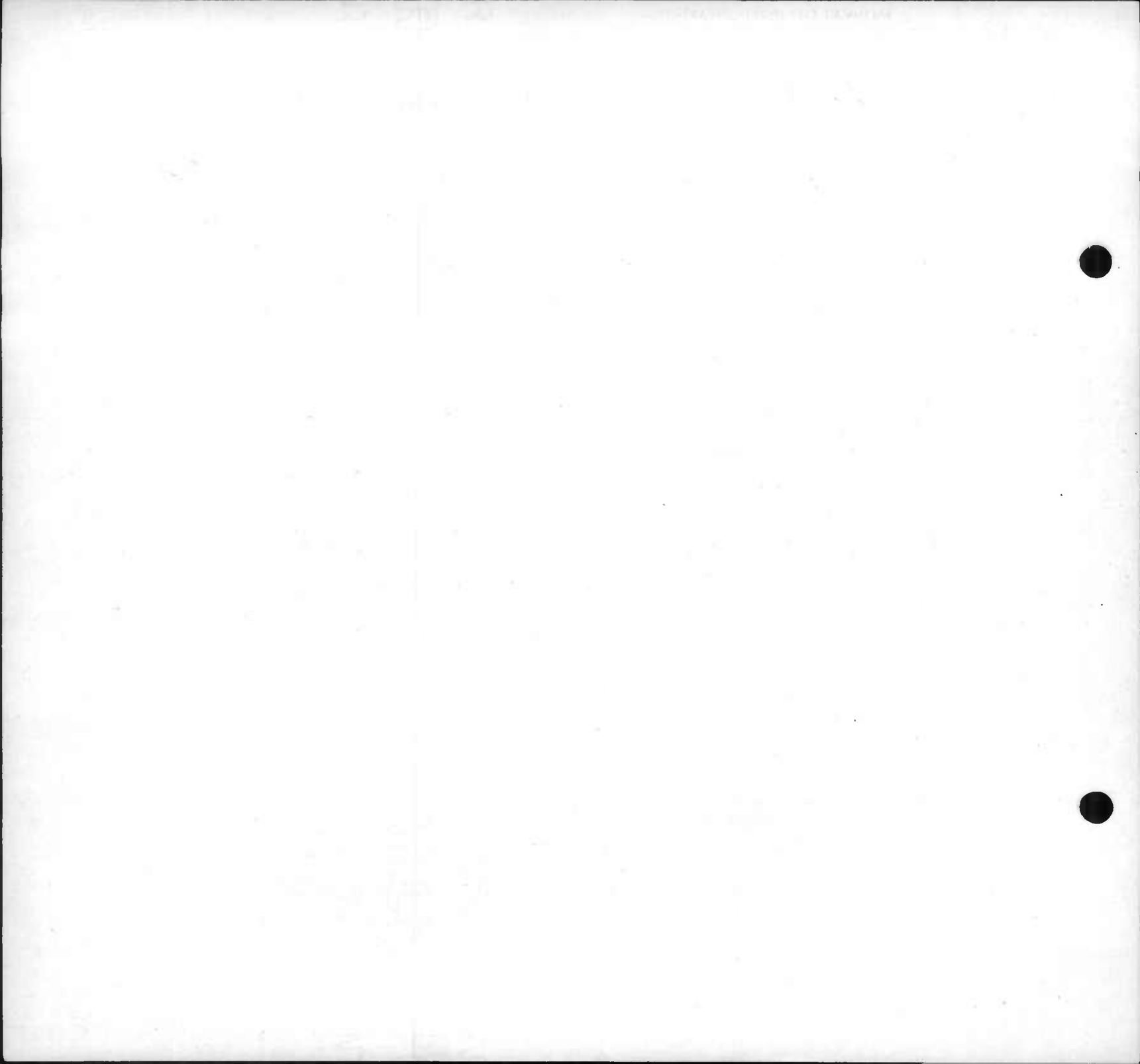
25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Kelson Funeral Home 1548 N. Calhoun St.

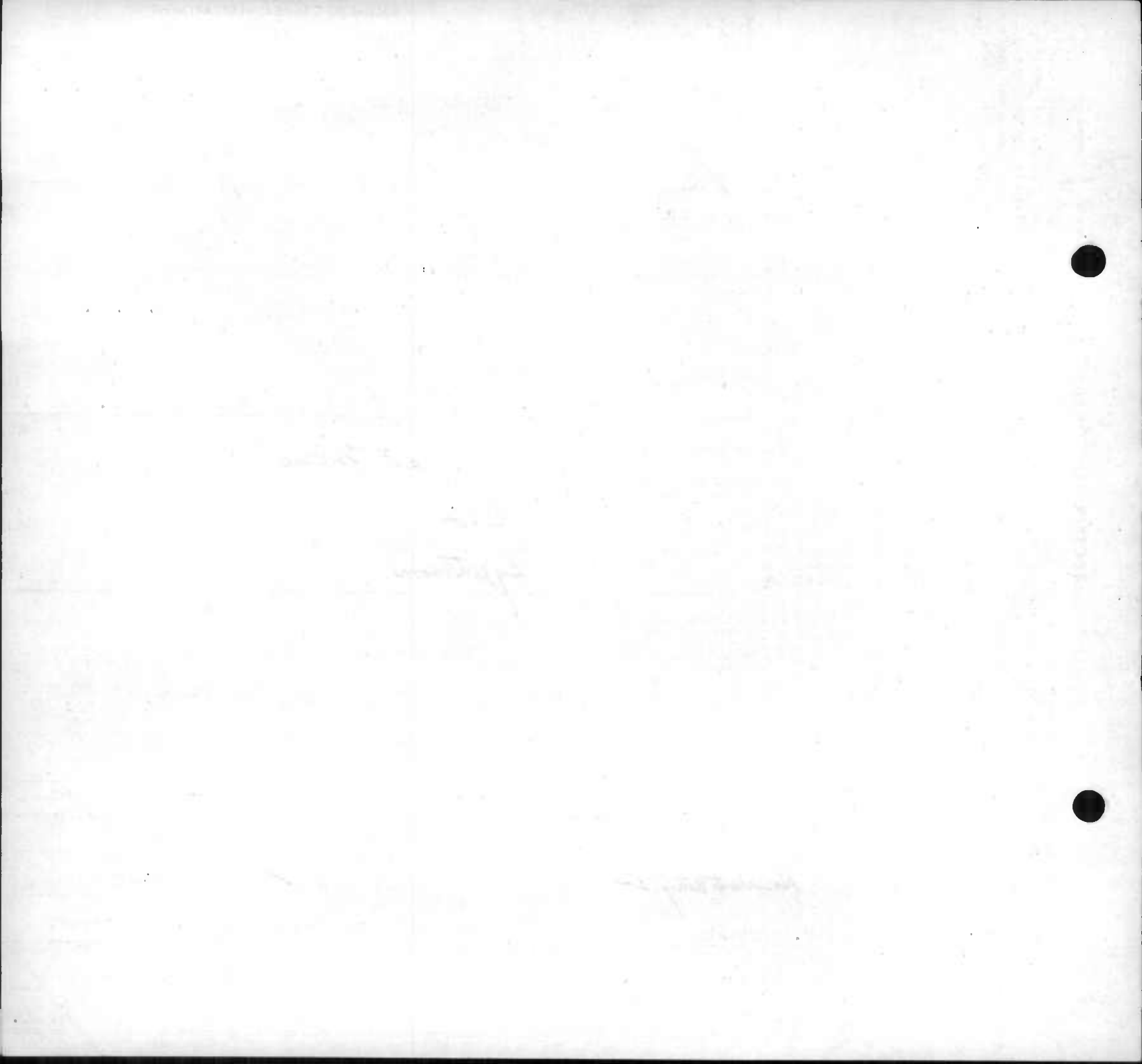
ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decreased vital signs; (6) A death in a hospital where the physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 68- 3955

VS 150-REV. 1/1/76



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RAYMOND WHITE Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>April 11, 1968 7:50 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 11, 1968 7:50 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>11-15-30</b>		10. AGE (In years lost birthday) <b>37</b>	
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Eastern Overall</b>		15. MOTHER'S MAIDEN NAME <b>Rebecca White</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Dorothy Bellford</b>		ADDRESS <b>3301 St Ambrose Ave</b>	
19. <b>430.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Ruptured intracranial saccular aneurysm</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 11, 1968</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Em. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>John E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		ADDRESS <b>1348 Calhoun St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## 68- 3957 CERTIFICATE OF DEATH

REG. NO.

68- 3957

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

*Foster, Lutil (Lutie)*

2. DATE AND HOUR OF DEATH

*4-10 '68*

*9:17 PM*

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

*Franklin Square Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*MD*

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

*Baltimore 23*

YES ☒ NO ☒

*1839 W. Lexington St*

5. SEX

*♀ F*

6. RACE

*N*

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

*2/24/14*

9. AGE (In years last birthday)

*54*

If Under 1 Yr.

Months

Days

Hours

Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*South Carolina*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Unknown*

14. MOTHER'S MAIDEN NAME

*Unknown*

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

*Unknown*

17. INFORMANT

ADDRESS

*Marie Richardson 2703 Raynor Ave*

18.

*3-21-0 I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

*FATTY LIVER*

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*CHRONIC ALCOHOLISM*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *April 10* 19 *68* to *April 10* 19 *68*. that (I) (we) last saw the deceased alive on *April 10* 19 *68* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Nak Joong Im*

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

*4-10 '68*

23C. PHYSICIAN'S NAME (Type)

*Nak Joong Im*

DEGREE

23D. ADDRESS

*Franklin Square Hospital*

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

*Burial 4-15-68*

24C. NAME OF CEMETERY OR CREMATORY

*Arbutus Mem. Pk.*

24D. LOCATION

(City, town, or county)

(State)

*Arbutus, Md.*

25A. DATE REC'D BY HEALTH DEPT.

*APR 15 1968*

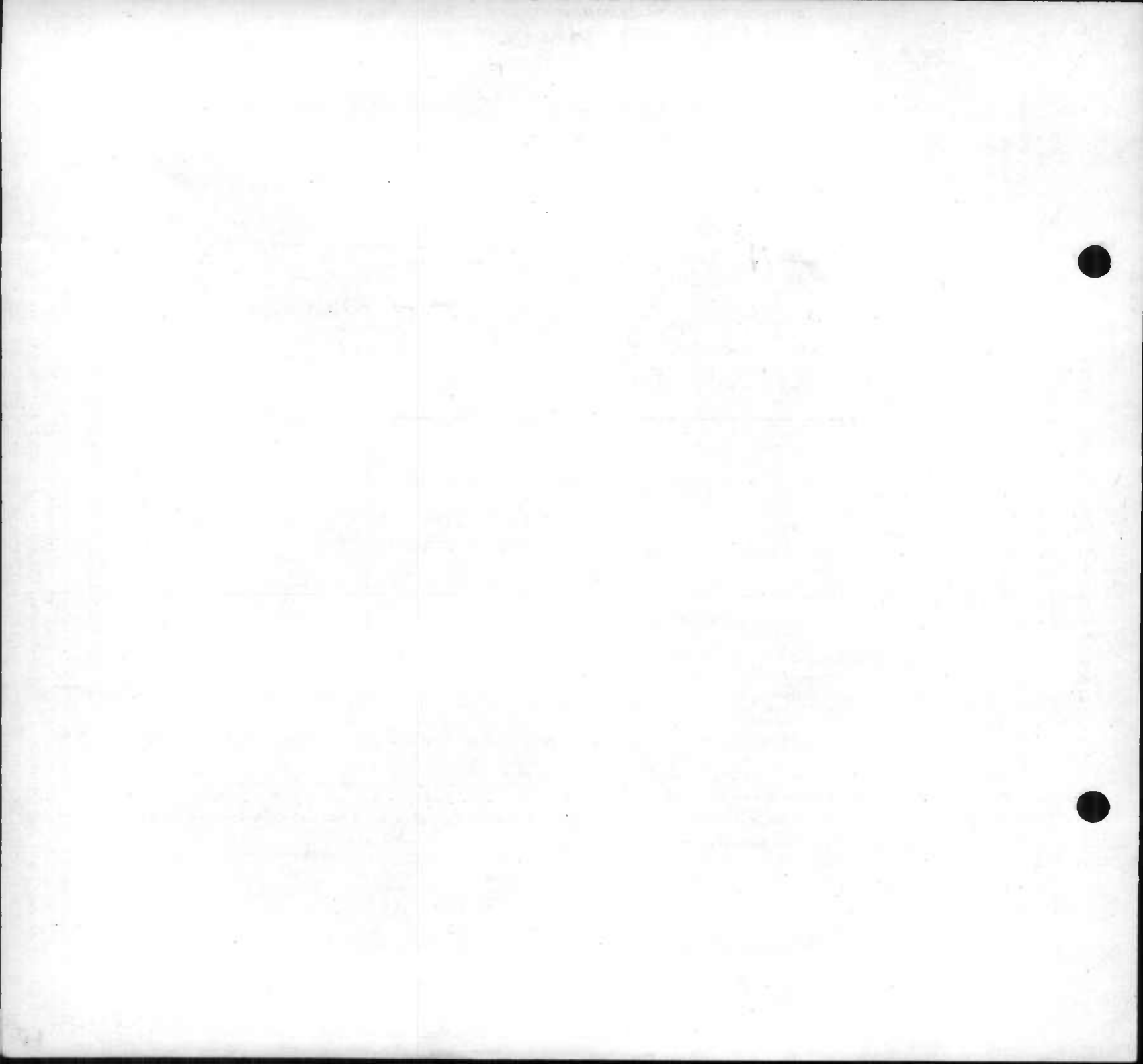
25B. NAME OF REGISTRAR

*Robert E. Taylor*

25C. FUNERAL DIRECTOR

*Helson Funeral Home 1348 Calhoun St*

ADDRESS



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3958

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>BERTHA SAUER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1900 Dixon Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 11, 1968 12:45 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>Feb. 10, 1877</b>		10. AGE (In years lost birthday) <b>91</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>220-05-9237B</b>	
18. INFORMANT <b>June M. Sullivan, 727 Leafydale Terr.</b>		15. MOTHER'S MAIDEN NAME <b>Louise ?</b>	
19. <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>422.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 11, 1968</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-13-1968</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz</b>	
25C. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>		ADDRESS <b>1050 York Road Towson, Maryland</b>	

WALLLEY 10010

FUNERAL DIRECTOR: IMPORTANT

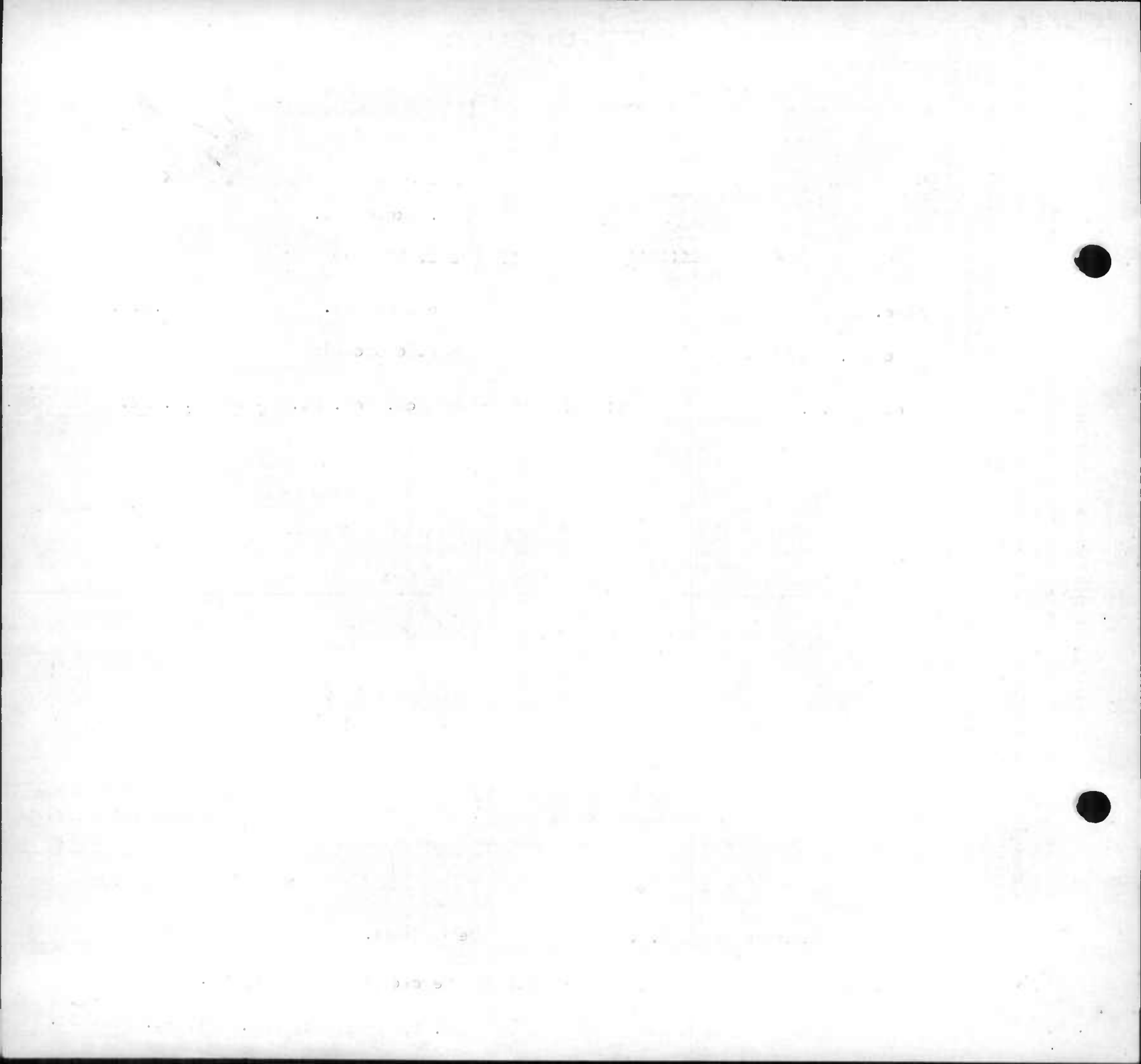
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3959

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3959

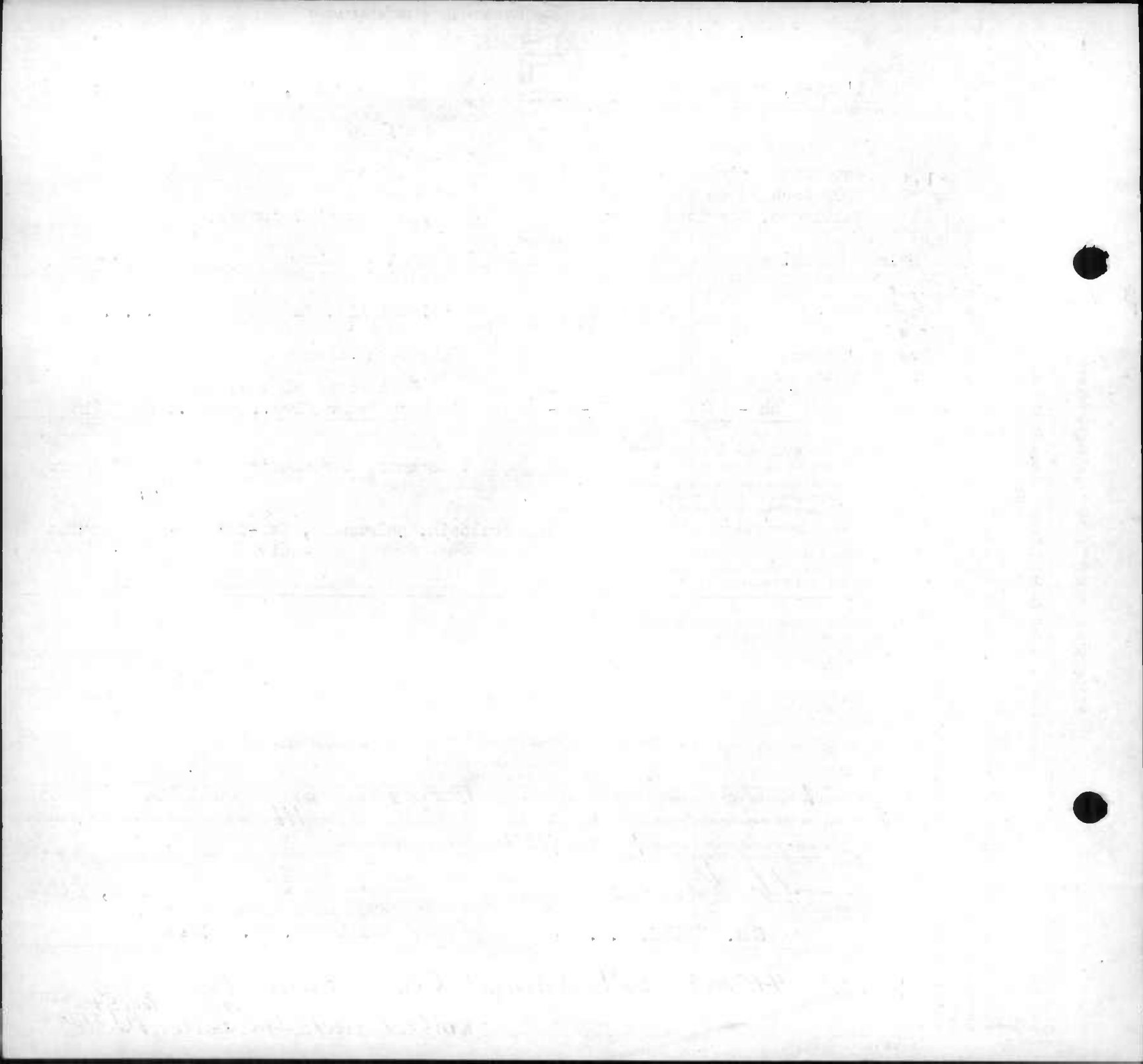
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Milton S. Stoudt</i>		2. DATE AND HOUR OF DEATH <i>April 6, 1968</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37 Mercy Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5 N. Exeter St.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 23, 1908</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mtce. man</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Allentown, Pa.</i>	
13. FATHER'S NAME <i>Benjamin Stoudt</i>			14. MOTHER'S MAIDEN NAME <i>Myrtle Brendle</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W.W.LI</i>		16. SOCIAL SECURITY NO. <i>XXX-XX-203-09</i>		17. INFORMANT ADDRESS <i>6383 Med. Rec. Ft. Howard V.A. Ft. Howard, Md.</i>	
18. <i>534.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>542.0 II</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Peripheal Circulatory collapse</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Bleed from GI tract</i> (C) <i>Stress ulcer</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days 4 weeks</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Removal artery thrombosis (L)</i>					
19A. DATE OF OPERATION <i>3-29-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Above knee amputation (L)</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-15-1968</i> to <i>4-6-1968</i> , that (I) (we) last saw the deceased alive on <i>4-6-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Pauline Ting</i>				23B. DATE SIGNED <i>4-6-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Pauline Ting, M.D.</i>				23D. ADDRESS <i>Mercy Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/11/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks, Inc. 1217 St. Paul St.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 3960</u>
68- 3960				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>O'Brien, Bernard NMI</b>		
2. DATE AND HOUR OF DEATH <b>April 8, 1968</b>		<b>7:50 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>511 S Hanover Street</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/12/21</b>	9. AGE (In years last birthday) <b>46</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Hanger</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Selfemployed</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Frank O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lehan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>1/15/44 - 4/2/46</b>		16. SOCIAL SECURITY NO. <b>572-16-9860</b>		17. INFORMANT <b>VA Hospital Records</b> <b>3900 Loch Raven Blvd., Balto., Md 21218</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>410915-011.2</b> <b>? Coronary thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Tuberculosis, pulmonary, far-advanced</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>420.1</b>				
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <b>February 5th 1968</b> to <b>April 8th 1968</b> , that (1) (we) last saw the deceased alive on <b>April 8th 1968</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.				
23A. SIGNATURE <b>David N. Marine</b>				23B. DATE SIGNED <b>April 12, 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>DAVID N. MARINE, M.D.</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Md. 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-15-1968</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>	24D. LOCATION <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>War Cook-Brooks, Inc. Balto., Md. 21202</b>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3961

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PATRICIA ANN YARBOROUGH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> <b>April 12, 1968</b>		3. DATE OF DEATH Month Day Year Hour <b>April 12, 1968 9:50 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>913 N. Washington Street</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY	
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-27-1938</b>		10. AGE (In years lost birthday) <b>29</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Yarborough</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Dunn</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Bendix Corp.</b>		17. SOCIAL SECURITY NO. <b>219-26-1165</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		19. INFORMANT <b>Mr. Henry Yarborough</b>		20. ADDRESS <b>913 N. Washington St.</b>	
19. <b>199.01</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinomatosis</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>199.21</b>					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/13/68</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-1968</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>		25D. ADDRESS <b>1735 Harford Avenue 21213</b>			

WILLIAM H. BROWN

NO 244 4 8 11 13 14

WILLIAM H. BROWN

WILLIAM H. BROWN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68-3962	
1. NAME OF DECEASED (Last, first, middle initial) <b>GEORGIANNA (Georgia) PARKER (VINSON)</b>				2. DATE AND HOUR OF DEATH <b>10 Apr 68 5:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>38110 Hope - Baltimore</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>MD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38110 Hope - Baltimore</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 7, 1905</b>	
9. AGE (In years, last birthday) <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>GANSEY McQUEEN</b>				14. MOTHER'S MAIDEN NAME <b>SALLIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ISAAC PARKER 863 W. LEXINGTON ST.</b>			
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>331X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Stroke (Cerebro) Hemorrhage 9 hrs</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>10 Apr 1968</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>10 Apr 1968</b> , that (I) (we) last saw the deceased alive on <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John A. Elkerton</b>				23B. DATE SIGNED <b>10 Apr 68</b>		23C. PHYSICIAN'S NAME (Type) <b>John A. Elkerton</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/15/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM PARK</b>		24D. LOCATION (City, town, or county) (State) <b>Balt Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Wm March</b>		25C. FUNERAL DIRECTOR <b>WM MARCH 928 E. NORTH AVE</b>			

C

Housewife

Connelly McQueen

Aug 5 1902

N.C.

State

Isaac Parker 303 W. Lexington St

Wm March 08 F North Ave

1000

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 3963

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN D. BRICE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 7, 1968</b> Hour: <b>6:20 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 7, 1968</b> Hour: <b>7:45 P.M.</b>	
6. SEX <b>male</b>	7. RACE <b>C white</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>May 17 1915</b>	10. AGE (In years lost birthday) <b>52</b>	11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Roxy Brice</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>250-14-4130</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty Alteration of liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>5-7-68</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED: <b>4/9/68</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/11/68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>	
25C. FUNERAL DIRECTOR <b>WM C MARCA</b>		ADDRESS <b>928 E North Ave</b>	

WALTON

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WALTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3964

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3964

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Streeter, George NMN		April 13, 1968 5:03 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		8. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland			
Veterans Administration Hospital		C. CITY OR TOWN		D. INSIDE CITY LIMITS	
3900 Loch Raven Blvd.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Baltimore, Maryland 21218		E. STREET AND NUMBER		1635 Poplar Grove	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/8/30	38	Machinist
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		Unknown		North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Clayton Streeter		Clara Dupree		United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 3/20/51-4/27/53		237-36-74-31		Records Veterans Administration Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		7 Mos.	
ANTECEDENT CAUSES		(B) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF:		4 Mos	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Bronchogenic Carcinoma		7 Mos	
162.1 II		Pulmonary Tuberculosis, Moderately Advanced, Quiescent.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from September 8, 1967 to April 13, 1968, that (X) (we) last saw the deceased alive on April 13, 1968 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Gordon F. Murray MD				4-14-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GORDON F. MURRAY MD		Veterans Hospital, Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/18/68		Balto Nat. Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Balto. Md.		WM MARCH 928 E NORTH AVE			
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 15 1968		Gordon F. Murray		WM MARCH 928 E NORTH AVE	

WM MARCH 278 E NORTH AVE

Belle Me

W/for Dole Not down

Transit

Veterans Hospital, Belle Me, N.J.

HD

W/for Dole Not down

-11-00

September 13

April 13

April 13

X

X

X

X

Department of the Interior,  
Bureau of Land Management,  
Washington, D.C.

Department of the Interior,  
Bureau of Land Management,  
Washington, D.C.

Department of the Interior,  
Bureau of Land Management,  
Washington, D.C.

Department of the Interior,  
Bureau of Land Management,  
Washington, D.C.

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Records

Department of the Interior,  
Bureau of Land Management,  
Washington, D.C.

2/20/51-4/27/52

2/20/51-4/27/52

Clayton Street

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A-325

68- 3965 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 3965

BIRTH NO. *Balto Co. Md., GBMC*

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>DARYL M. ATKINS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 12, 1968</b>		Hour <b>5:00 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 12, 1968</b>		Hour <b>6:59 P.</b>
6. SEX <b>male</b>		7. RACE <b>negro</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b>
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>1-17-68</b>		10. AGE (In years lost birthday) <b>2 mos.</b>		E. STREET AND NUMBER <b>446 E. Lorraine Avenue</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>JULIUS ATKINS</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>YVONNE E SCOTT</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Julius ATKINS 446 E Lorraine Ave</b>

MEDICAL CERTIFICATION	19. <b>484X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Interstitial Pneumonitis (SDII)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>5-25-X II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH <b>Interstitial Pneumonitis (SDII)</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	20A. DATE OF OPERATION <b>7</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
	22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/13/68</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/17/68</b>		24C. NAME of CEMETERY or CREMATORY <b>Balto Not. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE RECEIVED BY HEALTH DEPT <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>		25C. FUNERAL DIRECTOR <b>Wm. MARSH</b>		ADDRESS <b>928 E. North Ave.</b>

1-17-68

MD

Julius Atkins

Yvonne E Scott

Julius Atkins and Yvonne E Scott

*[Handwritten signature]*

1-17-68

Julius Atkins

Yvonne E Scott

MD

Wm. Morris and Yvonne E. Scott

M 200

68-3966

BALTIMORE CITY HEALTH DEPARTMENT

68-3966

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur Musk

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

4

13

68

5:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00306 W. Franklin St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

4

13

68

5:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

11-03

6. SEX

M

7. RACE

W

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

BALTIMORE

YES ☒ NO ☐

9. DATE OF BIRTH

July 11, 1887

10. AGE (In years lost birthday)

80

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

306 W. Franklin St.

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Musk

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

385-09-2240

18. INFORMANT

Henry A. Musk, Glen Burnie, Md. 21061

ADDRESS

7833 Americana Circle

19. 412.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic Cardiovascular Disease

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)Werner H. Spitz M.D.  
Werner H. SpitzCHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4.14.68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-15-68

24C. NAME of CEMETERY or CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Witzke Funeral Directors, Balto., Md. 21229

4101 Edmondson Avenue

NO  
BOLIMORE  
21 E. W. Franklin

who is in the bank  
Lester D. Jones

WALL LEX 30101011

24

W. V.

W. V. Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-3967		68-3967		CERTIFICATE OF DEATH		REG. NO. _____							
1. NAME OF DECEASED (Type or Print) <b>Lillian E. Johnson</b>						2. DATE AND HOUR OF DEATH <b>April 12, 1968</b> M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOODS NURSING HOME</b>						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4618 Manordene Road</b>											
5. SEX <b>Female</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 24, 1893</b>		9. AGE (In years last birthday) <b>75</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sewing Machine Operator</b>						10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>							
13. FATHER'S NAME <b>Andrew Johnson</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Hanson</b>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-05-7855</b>		17. INFORMANT <b>Lillian E. Johnson, Baltimore, Md. 21229</b>				ADDRESS <b>4618 Manordene Road</b>							
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Generalized CAR-1 YRT</b> <b>CIROMATOSIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
												19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>199.2 II</b> <b>ARTERIOSCLEROTIC CVDISEASE 1 YRT</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> 19 <b>67</b> to <b>4/12</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>12/11</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE <b>Thomas E. Roach</b>						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>4/13/68</b>							
23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Roach, M. D.</b>						23D. ADDRESS <b>5550 Balto. Nat'l Pike, Balto., Md.</b>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-15-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>									
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				25C. FUNERAL DIRECTOR <b>Witzke Funeral Directors, Balto., Md. 21229</b>									
ADDRESS <b>4101 Edmondson Avenue</b>																	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 3968
BIRTH NO. 68- 3968		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) THERESA EBB		2. DATE AND HOUR OF DEATH 4/10/68 2:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 20-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1811 Lanetta Ave		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1900	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME ADOLPHUS WOODWARD		14. MOTHER'S MAIDEN NAME MARGARET NOKES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-18-9996-A		17. INFORMANT Bertha Campbell, 3503 Eldorado Ave.
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) HASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours YEARS
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 420.1 II				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/10/68 19 to 4/10 19 68 that (I) (we) last saw the deceased alive on 4/10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Queral		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/10/68
23C. PHYSICIAN'S NAME (Type) F. QUERAL		23D. ADDRESS LUTHERAN HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-68		24C. NAME OF CEMETERY OR CREMATORY Baltimore, National
24D. LOCATION (City, town, or county) Baltimore, Maryland		(State) Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 15 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.
ADDRESS				

1947-48  
1948-49  
1949-50

1950-51 1951-52 1952-53

1953-54 1954-55

1955-56 1956-57 1957-58

1958-59 1959-60 1960-61

1961-62

1962-63

1963-64

1964-65

x

1965-66 1966-67 1967-68

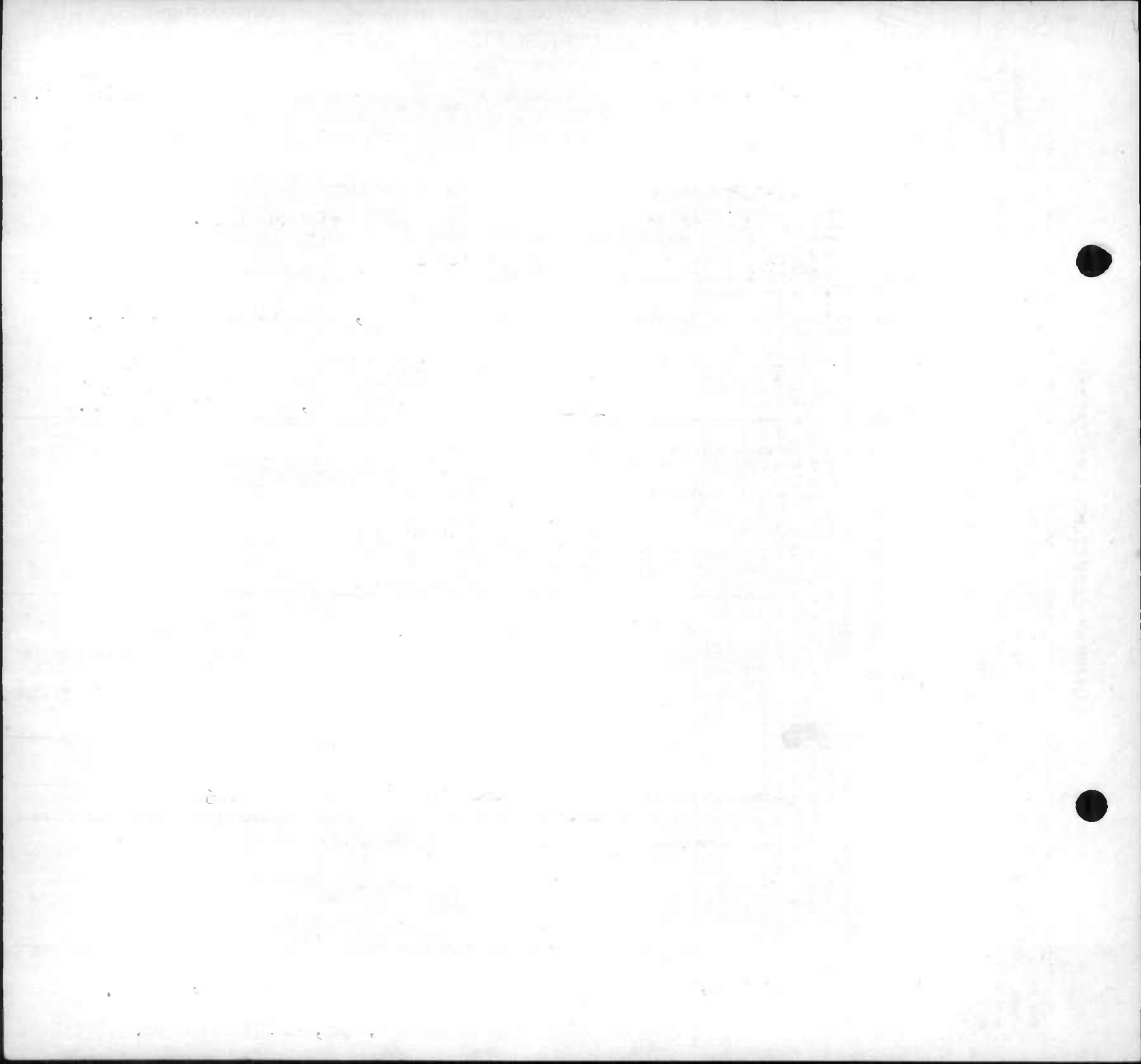
1968-69

1969-70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

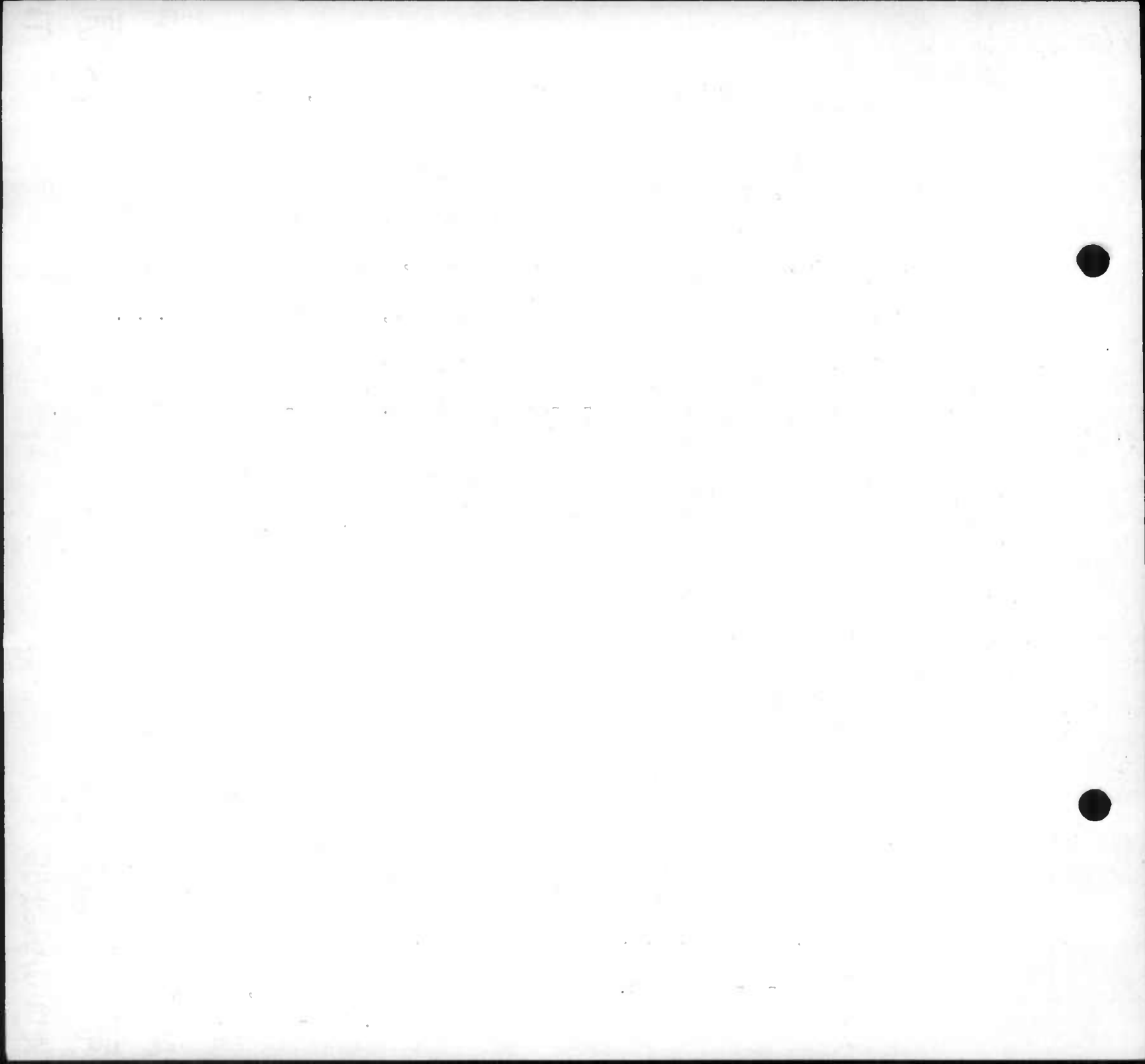
BIRTH NO. 68-3969				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3969															
CERTIFICATE OF DEATH																							
1. NAME OF DECEASED (Type or Print) <b>Redmond, Bossie</b>						2. DATE AND HOUR OF DEATH <b>4-6-68 11:35 p.m.</b>																	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-04</b>																	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>39 Provident Hospital 1514 Division Street Baltimore, Maryland</b>						C. CITY OR TOWN <b>Baltimore</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
						E. STREET AND NUMBER <b>2338 Reisterstown Rd.</b>																	
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-13-05</b>		9. AGE (In years last birthday) <b>62</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.													
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia, Heathsville</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>														
13. FATHER'S NAME <b>William Cockrell</b>						14. MOTHER'S MAIDEN NAME <b>Hanna Kenner</b>																	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-32-4964</b>		17. INFORMANT ADDRESS <b>Columbus Redmond, 2338 Reisterstown Rd.</b>																	
18. <b>431.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL HEMORRHAGE</b> (B) ESSENTIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ARTERIOSCLEROSIS</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
												19. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
												20A. AUTOPSY? (Yes or No)						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
												21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
21F. HOW DID INJURY OCCUR?						22. I certify that (I) (this hospital) attended the deceased from <b>4-2-68</b> 19 to <b>4-6-68</b> 19, that (I) (we) last saw the deceased alive on <b>4-6-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																	
23A. SIGNATURE <b>G. L. Banfield M.D.</b>						23B. DATE SIGNED																	
23C. PHYSICIAN'S NAME (Type) <b>G. L. BANFIELD M.D.</b>						23D. ADDRESS <b>722 N. Fulton Ave. Balt. Md.</b>																	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>April 9, 68</b>		24C. NAME OF CEMETERY or CREMATORY <b>First Baptist Church</b>				24D. LOCATION (City, town, or county) (State) <b>Heathsville, Va.</b>													
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles R. Law, 802 Madison Ave.</b>																	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">68- 3970</span>	
68- 3970				CERTIFICATE OF DEATH	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>ETHEL (FANNIE) HUNTER</b>			APRIL 9, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>15-13</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4120 REISTERSTOWN ROAD</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5, 1914</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>RICHMOND, VIRGINIA</b>	
13. FATHER'S NAME <b>WILLIAM JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>BETTY STEWART</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>092-09-3980</b>		17. INFORMANT <b>HENRY R. HUNTER - 4120 REISTERSTOWN RD.</b>	
18. <b>47501</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS Generalized</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROSIS Generalized</b> (C).....		
19. DATE OF OPERATION <b>420.0 II</b>			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1960</b> to <b>APRIL 9 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 9 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. H. Banfield M.D.</b>				23B. DATE SIGNED <b>4/11/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Gilbert L. Banfield, M.D.</b>		23D. ADDRESS <b>722 N. Fulton Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-13-68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. AUBURN</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>CHARLES R. LAW - 802 MADISON AVENUE</b>			



W-420

68-3971

BALTIMORE CITY HEALTH DEPARTMENT

68-3971

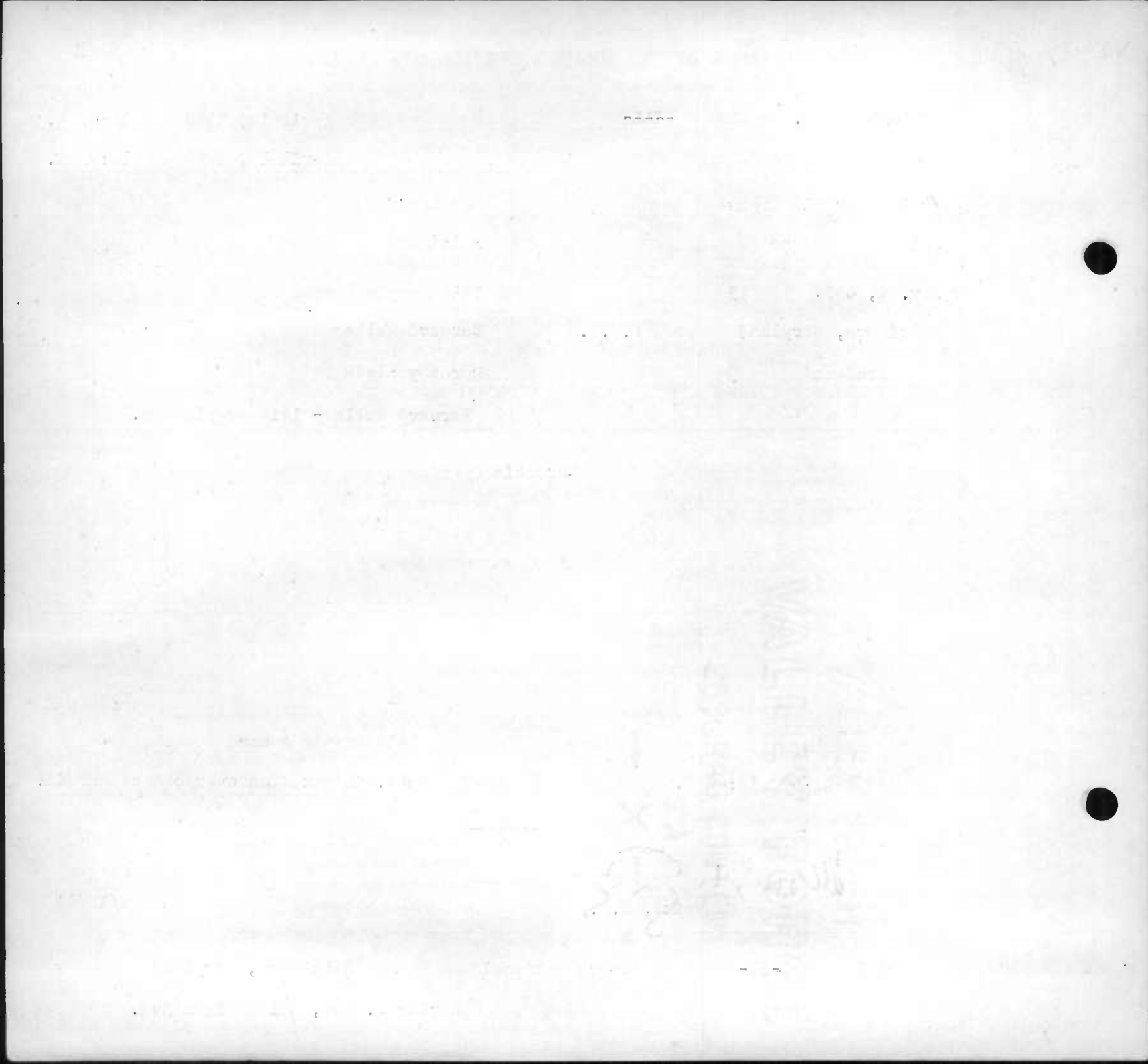
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BERNARD T. WELLS WILLS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 12, 1968</b> 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1416 Argyle Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 12, 1968</b> 10:45 A.M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 9, 1952</b>		10. AGE (In years last birthday) <b>15</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME <b>Dorothy Slade</b>		18. INFORMANT <b>Bernard Wells - 1416 Argyle Ave.</b>	
19. <b>E 83-B.O</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Narcotic Overdose</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b> <b>E 83-B.O</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>4/11/68 10:00 P.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1416 Argyle Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Subj. injected an overdose of heroin.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/13/68</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-17-68</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles R. Law, 802 Madison Ave.</b>		ADDRESS	

W 963.0



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ISABEL MORTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 7, 1968</b> Hour <b>4:00 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2007 N. Bentalou Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 9, 1968</b> Hour <b>4:20 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
6. SEX <b>female</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>July 28, 1892</b>		10. AGE (in years last birthday) <b>75</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Farmville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	E. STREET AND NUMBER <b>2007 N. Bentalou Street</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	15. MOTHER'S MAIDEN NAME <b>Besty Ann Spriggum</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>217-20-8484</b>	18. INFORMANT ADDRESS <b>Mrs. Jane Lyles 1710 Moreland Ave</b>
19. CAUSE OF DEATH <b>412.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):  20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/10/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/13/68</b>	24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>	25C. FUNERAL DIRECTOR ADDRESS <b>3035 W. North Ave</b>

Wm. H. Smith

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3973

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3973

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

REDD, Mrs Ursula

2. DATE AND HOUR OF DEATH

April 10, 1968

8:40

a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Jenkins Memorial Hospital  
1000 S Caton Ave.  
Baltimore, Md. 212294. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

1058 Argyle Ave.

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2/11/1895

9. AGE (In years  
last birthday)

73

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Housekeeping

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Phil Gardner

14. MOTHER'S MAIDEN NAME

Belle Williams

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

219 30 7234 A

17. INFORMANT

ADDRESS

Medical Records -Jenkins Memorial Hosp.

18. I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer colon &  
metastases

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 months

MEDICAL CERTIFICATION

15-3-8 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Anterior cholelithiasis &amp; severe

1 yr.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~he~~ (this hospital) attended the deceased from 3/11/68 to 4/10/68  
that ~~he~~ (we) last saw the deceased alive on 4/10/68 and that in (my) ~~own~~ opinion death occurred on the date  
and hour and from the causes stated above. ~~He~~ (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE

J. Raymond Gladue

Attending  
Phys. ☐Med.  
Director ☒Staff  
Phys. ☐

23B. DATE SIGNED

4/10/68

23C. PHYSICIAN'S  
NAME (Type)

J RAYMOND GLADUE, M. D.

23D. ADDRESS

1000 S Caton Ave. Balto., Md 21229

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/15/68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Jenkins

25C. FUNERAL DIRECTOR

Herbert Mutter

ADDRESS

3035 W. North Ave

J. M. Howard



*Faint, illegible handwriting at the bottom of the page.*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# BALTIMORE CITY HEALTH DEPARTMENT 68- 3974 CERTIFICATE OF DEATH

REG. NO.

68- 3974

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AREY JENSON WASHINGTON

2. DATE AND HOUR OF DEATH

APR 13, 1968 6:00 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTO

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

CATONSVILLE

YES ☒ NO ☐

E. STREET AND NUMBER

81 WINTERS AVE

53-00

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

FEMALE

NEGRO

WIDOWED ☐ DIVORCED ☐

11/11/17

51 yrs

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

HOUSEWIFE

Home

MARYLAND

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

JOSEPH JENSON

BESSIE NEAL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

NO

217-05-4100

Mr Rufus Washington 81 Winter Ave. MEDICAL RECORD

18. 174X I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

METASTATIC CARCINOMA OF BREAST

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

170X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐

Not While At Work ☐

22. I certify that (1) (this hospital) attended the deceased from April 2, 1968 to April 13, 1968, that (1) (we) last saw the deceased alive on April 12, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William Edward Mock

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

April 13, 1968

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

4/17/68

Baltimore National Cem.

Baltimore CO. MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

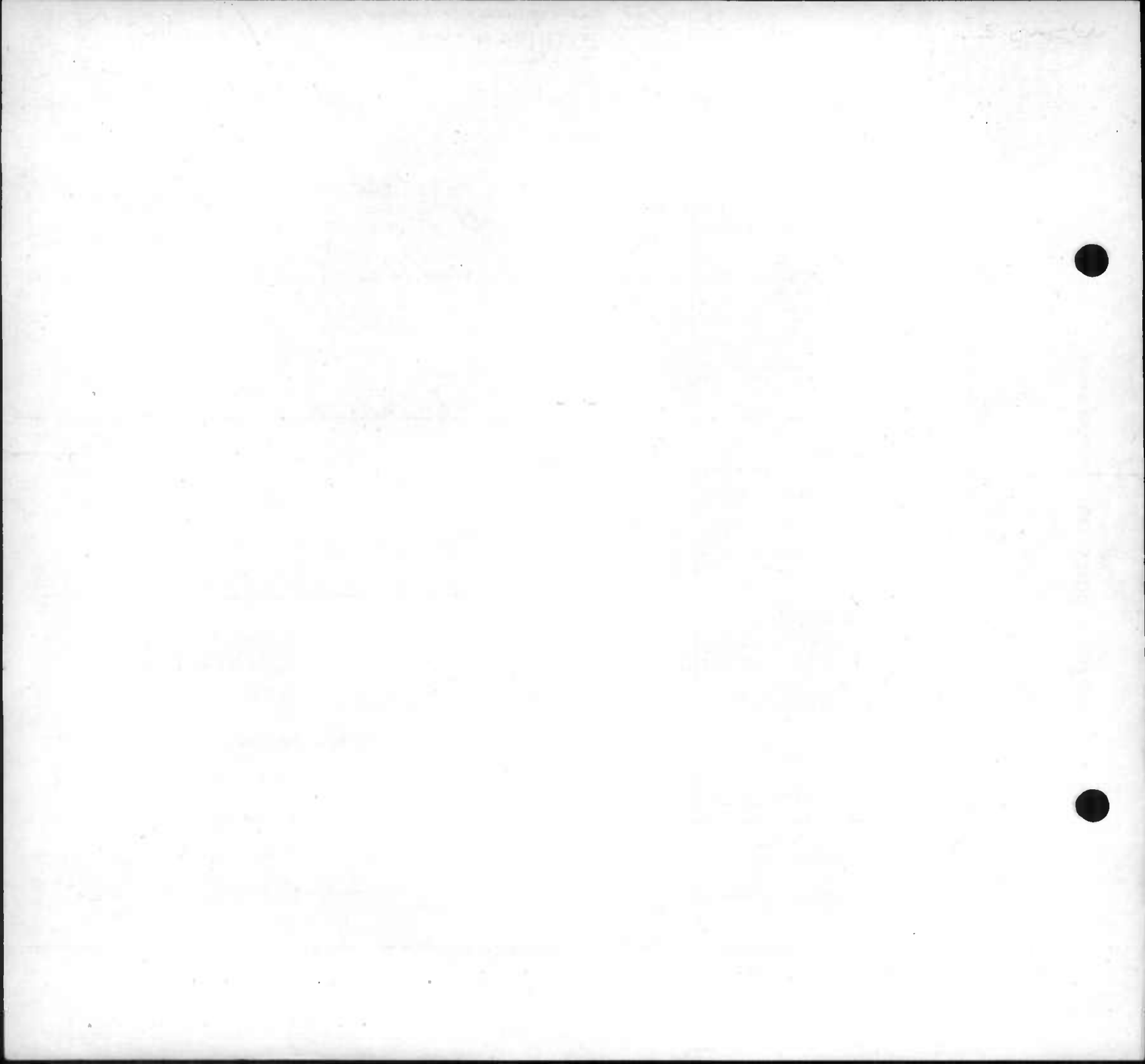
25C. FUNERAL DIRECTOR

ADDRESS

APR 15 1968

Herbert E. Nutter

Herbert E. Nutter 3035 W. North Ave.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3975

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 3975

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Rothchild Moore

2. DATE AND HOUR OF DEATH

4/5/68

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1505 N. Pulaski Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

1505 N. Pulaski St.

D. INSIDE CITY LIMITS?

YES ☒ NO ☒

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/16/03

9. AGE (In years  
last birthday)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mail Handler

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

Calvert County MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Benson Moore

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Moore

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL  
SECURITY NO.

216-44-3360

17. INFORMANT

ADDRESS

Mrs Mary H. Moore 1505 N. Pulaski St.

18. 4/10/68 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Myocardial Infarction

(B) *Atherosclerosis*  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_,  
that (I) (we) last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frank W. Washington, M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

4/9/68

23C. PHYSICIAN'S  
NAME (Type)

Frank W. Washington M.D.

23D. ADDRESS

2309 Druid Hill Ave.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/10/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore CO. MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

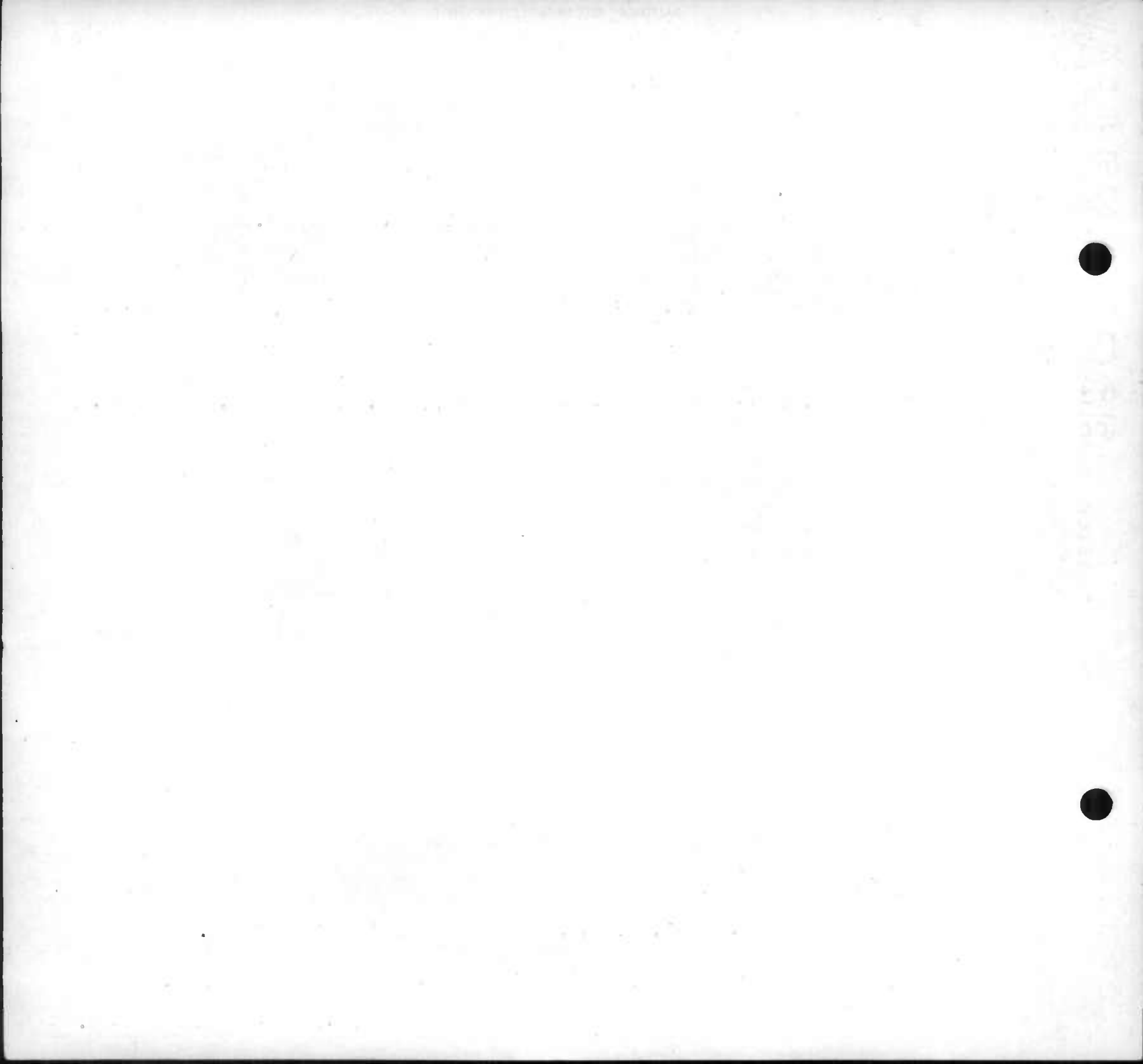
25C. FUNERAL DIRECTOR

ADDRESS

APR 15 1968

Herbert E. Nutter

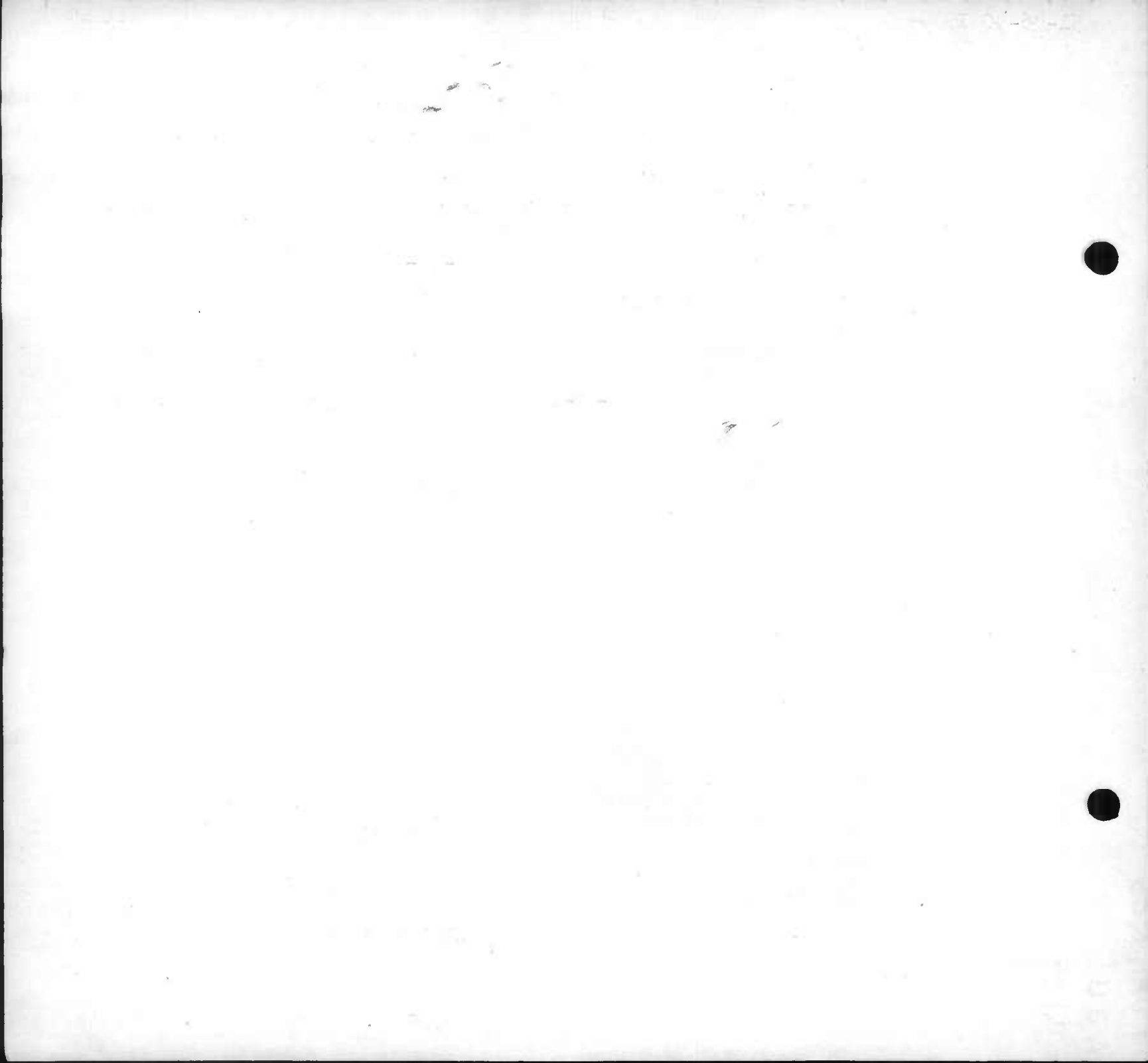
Herbert E. Nutter 3035 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-3976	
51-46-4b 1B		68-3976		G-252	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas J. Goggins</i>			
2. DATE AND HOUR OF DEATH <i>4-12-68 4:30</i> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-03</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2424 WOODBROOK AVE. #21217</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-13</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Greenwood SOUTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>YANCEY GOGGINS</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA CLAYBORN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>251-03-4801</b>		17. INFORMANT ADDRESS <b>RECORDS-BCH-4940 EASTERN AVENUE</b>	
18. <i>018.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Possible military Tuberculosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Laennec's cirrhosis</i> (C) <i>Peptic ulcer disease</i> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		19. <i>019.2 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-5</i> 19 <i>68</i> to <i>4-12</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-12</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mark Lowmiller</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-12-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mark Lowmiller</i>		23D. ADDRESS <b>21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/17/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Balto Co. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>68-3977</b>
BIRTH NO. <b>68-06448 68-3977</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Thomas Lloyd Cooper Gaither</b>		2. DATE AND HOUR OF DEATH <b>APRIL 7, 1968 9:35A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVES. BALTIMORE, MD. 21229</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04-04-68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <b>2 10 29</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Thomas Lloyd Gaither Jr.</b>		14. MOTHER'S MAIDEN NAME <b>FAY L. COOPER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES RECORDS - CATON &amp; WILKENS AVES</b>
18. <b>03891</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Spinal Meningitis</b> (B) <b>Neonatal Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>768.0 II</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <b>APRIL 4 1968</b> to <b>APRIL 7 1968</b> , that (X) (we) lost saw the deceased alive on <b>APRIL 7 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>John K. Weagly, M.D.</b>				23B. DATE SIGNED <b>9 April 1968</b>
23C. PHYSICIAN'S NAME (Type) <b>JOHN WEAGLY, M.D.</b>		23D. ADDRESS <b>CATON &amp; WILKENS AVES., BALTO 21229 MD.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/12/68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Herbert E. Nutter-3035 W. North Ave.</b>		

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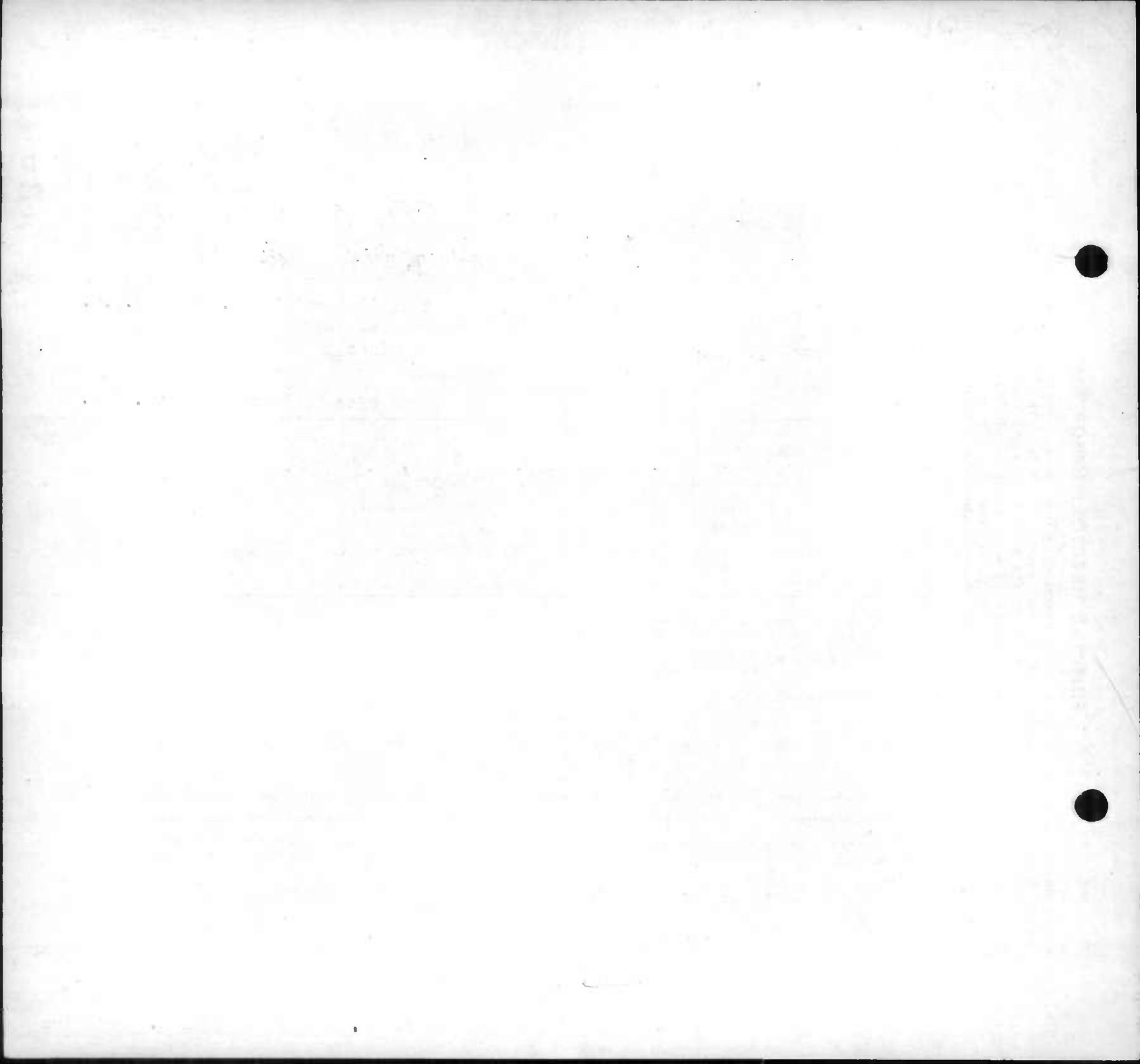
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3978

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3978

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDY M. RICE</b>		2. DATE AND HOUR OF DEATH <b>4-7-68 7:45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Sinner Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb 17, 1905</b>		9. AGE (In years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Mc Callisterville Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Effe Mathews</b>	
14. MOTHER'S MAIDEN NAME <b>Amy Imes</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr Howard Rice 5511 Kennison Ave. Apt. H</b>		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) <b>ASSTVD</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
19. DATE OF OPERATION <b>4-20-68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-7-68</b> to <b>4-7-68</b> , that (I) (we) lost saw the deceased alive on <b>4-7-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Garry Kereitman MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Garry Kereitman</b>				23D. ADDRESS <b>Sinner Hosp Baltimore</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>APR 15/1968</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. STATE <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15/1968</b>	
25B. NAME OF REGISTRAR <b>Herbert E. Nutter</b>		25C. FUNERAL DIRECTOR <b>Herbert E. Nutter</b>		25D. ADDRESS <b>3035 W. North Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

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68- 3979

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3979

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Leonard Bell Scheler, Sr.

2. DATE AND HOUR OF DEATH

April 13, 1968 6:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5939 Theodore Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

Maryland --

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

5939 Theodore Avenue

INSIDE CITY LIMITS?

YES ☒ NO ☐

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 23, 1905

9. AGE (In years last birthday)

62

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shipping clerk

10B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Scheler

14. MOTHER'S MAIDEN NAME

Anna Bell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-07-0648

17. INFORMANT

Agnes E. Scheler 5939 Theodore Ave

ADDRESS

21214

18. 4-12-91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1955 to 4-13 1968, that (I) (we) last saw the deceased alive on 3-11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*John C. Hyle*

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/15/68

23C. PHYSICIAN'S NAME (Type)

John C. Hyle

M.D.

23D. ADDRESS

7527 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/16/68

24C. NAME OF CEMETERY or CREMATORY

Moreland Mem. Park Cem. Taylor Ave. Balto Md.

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

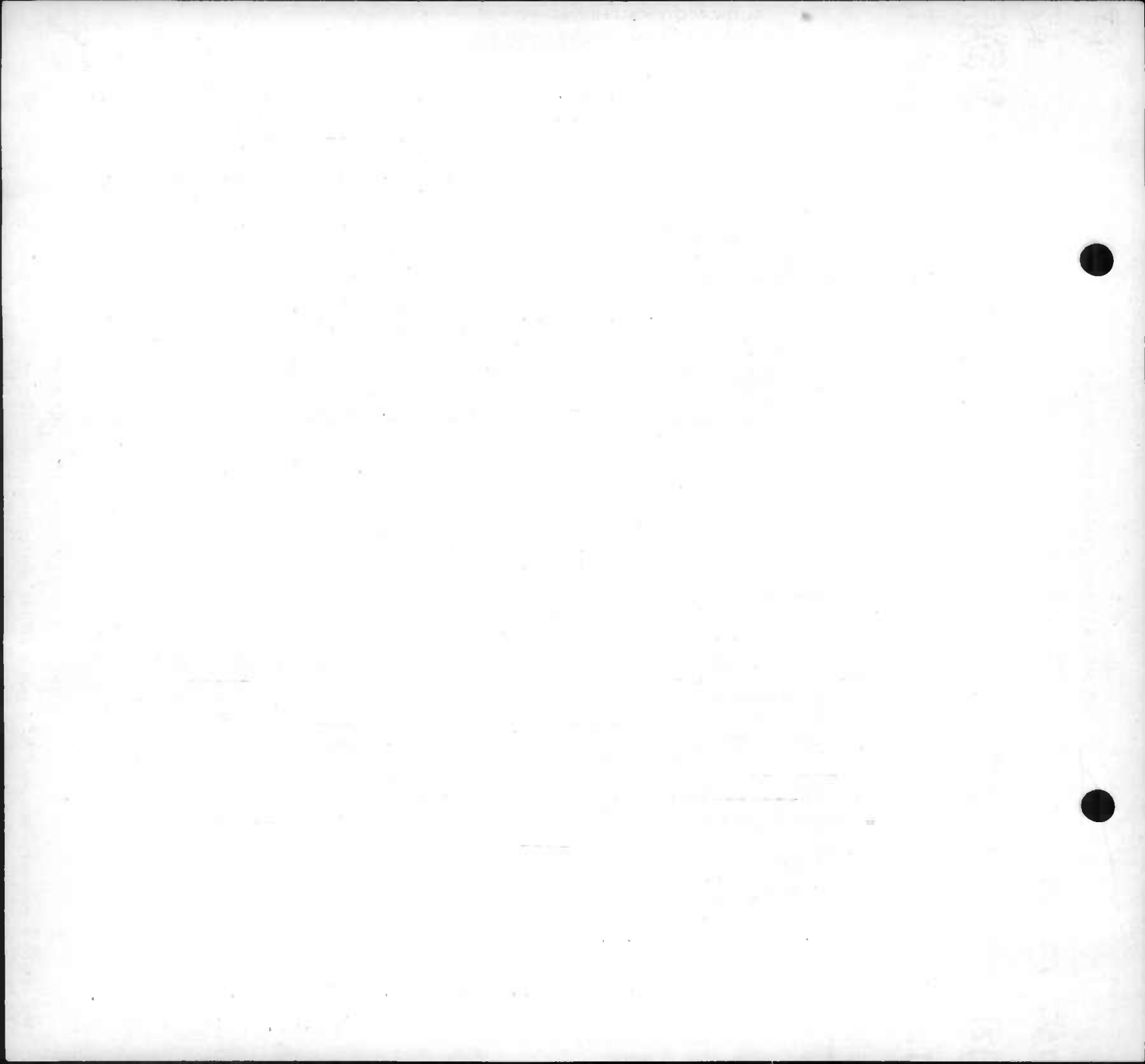
25C. FUNERAL DIRECTOR

ADDRESS

APR 15 1968

*Robert E. Faldut*

Dippel Bro's Inc. 7110 Belair Rd



FUNERAL DIRECTOR: IMPORTANT

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68- 3980

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3980

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LILLAIN ESTELLE GRAP

2. DATE AND HOUR OF DEATH

APRIL 12, 1968

7:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3813 Fleetwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE 21206

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4205 Woodstock Avenue

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Jan. 14, 1900

9. AGE (In years last birthday)

68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew J. Chenoweth

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Haas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

215 30 0334

17. INFORMANT

ADDRESS

Mrs Lillian E. Platt, 3813 Fleetwood

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Congestive Heart Failure

(B) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerosis

(C) DUE TO, OR AS A CONSEQUENCE OF:

Diabetes Mellitus

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 mo.

10 yrs

10 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1950 to 4-12-1968, that (I) (we) last saw the deceased alive on 4-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John Duer Moores M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

April 12, 1968

23C. PHYSICIAN'S NAME (Type)

John Duer Moores M.D.

23D. ADDRESS

3105 Belair Road Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/15/68

24C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

BALTIMORE, MARYLAND 21213

ADDRESS

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68-3981		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 68-3981	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Thomas P. Gunning</i>		2. DATE AND HOUR OF DEATH <i>April 13, 1968 9:50 p.m.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> <i>44</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1532 Stonewood Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED/NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>08-20-99</i>	9. AGE (In years last birthday) <i>68 Years</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James A. Gunning</i>		14. MOTHER'S MAIDEN NAME <i>Margaret A. Reilly</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>		16. SOCIAL SECURITY NO. <i>705-10-0107</i>	17. INFORMANT <i>Mrs. Margaret J. Gunning</i>		ADDRESS <i>Same</i>
18. <i>3-25-XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary embolism</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardiac Arrest</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>4-3-1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Closure of Cholecystectomy</i>		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>N</i> (this hospital) attended the deceased from <i>3-30-1968</i> to <i>4-13-1968</i> , that <i>N</i> (we) last saw the deceased alive on <i>4-13-1968</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nabil Ibrahim Fanous</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4-13-1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>NABIL IFRAHIM FANOUS</i>		23D. ADDRESS M.D. <i>THE UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4-17-68</i>	24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home, Inc.</i> <i>6500 York Rd. Baltimore, Md. 21212</i>	



3103 51 APR 2  
RECEIVED N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-400		68-3982		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-3982	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Mary Reilly</u>			
2. DATE AND HOUR OF DEATH <u>4/8/68 7:35 P.</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN <u>BALTIMORE</u> E. STREET AND NUMBER <u>2100 BARCLAY STREET</u>			
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-89</u> 9. AGE (In years last birthday) <u>78</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS HENNESSEY</u>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-5071-A</u>		17. INFORMANT ADDRESS <u>P.J. Reilly 2100 Barclay St.</u>			
18. <u>4/10/68</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute MI. (P) CVA</u> <u>ASCVD.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>14 days</u> <u>years</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>420.1 II</u> <u>Acute Tubular Necrosis, GI bleeding</u>				20. DATE OF OPERATION <u>0</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> 19 <u>68</u> to <u>4/8</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John R. Sharp MD</u>				23B. DATE SIGNED <u>4/8/68</u>		23C. PHYSICIAN'S NAME (Type) <u>JOHN R. SHARP, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/11/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell Wiedefeld Home 6500 York Rd.</u>			

12 OCT 1964

12 OCT 1964

12 OCT 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-3983

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68-3983

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Austin T. Kernan

2. DATE AND HOUR OF DEATH

4-12-68 9:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

MD 7

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2841 N. CALVERT ST

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12-21-05 62

9. AGE (In years last birthday)

If Under 1 Yr. Months: Ooys

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene T. Kernan

14. MOTHER'S MAIDEN NAME

CLARA JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Gene Kernan 6003 Hunt Club Lane #21210 Hospital Records---

ADDRESS

18. 3-77-01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Marked Pulmonary Edema minutes  
in infarcted tissue in bronchi.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Acute Hemorrhagic Pancreatitis days.

(C)

3-27-0 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

3 4.8.68.

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Acute Abdomen

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-8-68 to 4-12-68, that (I) (we) last saw the deceased alive on 4-12-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jean M. Thorne

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4.12.68.

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/15/68

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto.

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

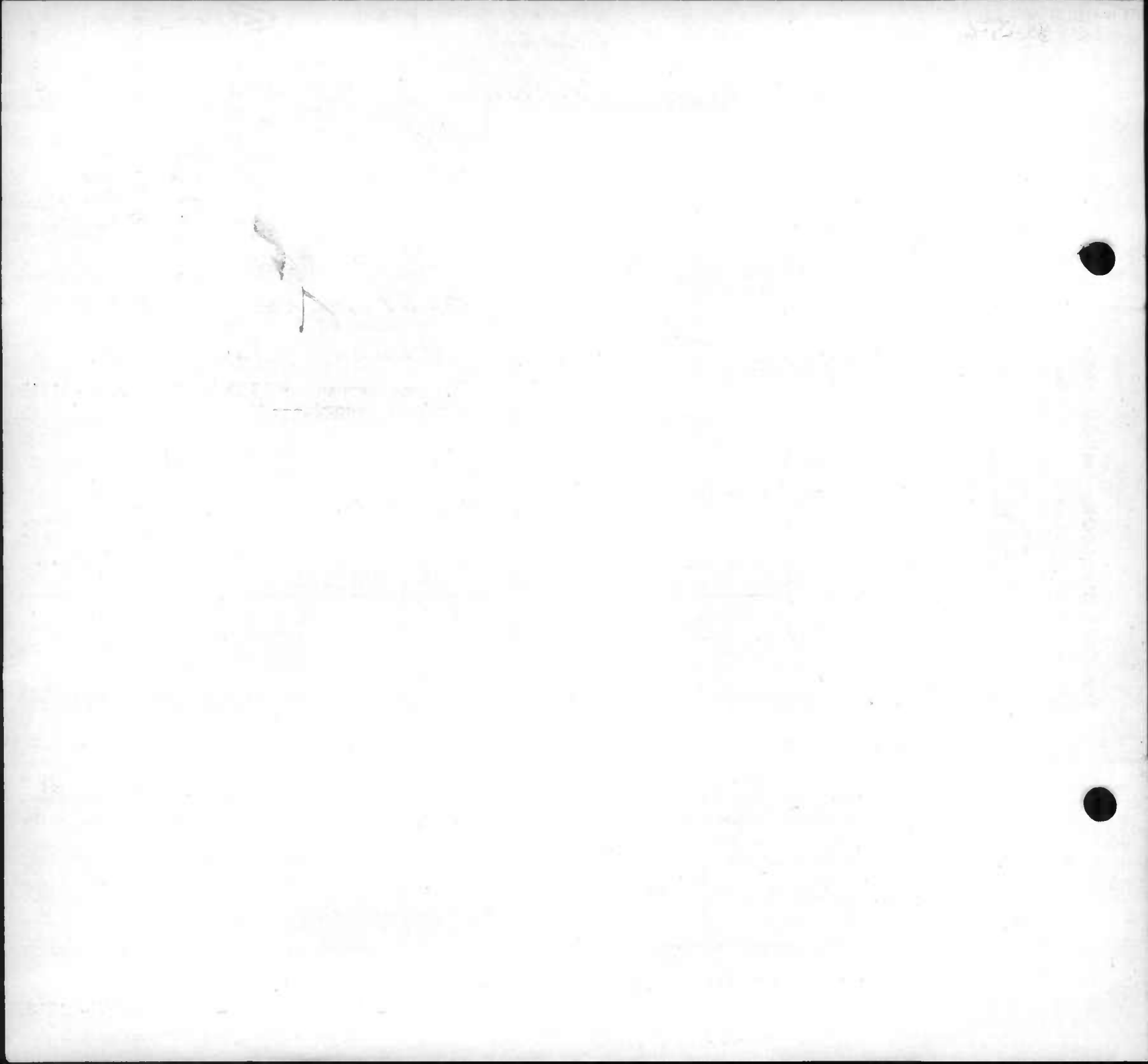
25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

Mitchell-Wiedefeld Home-6500 York Rd-21212

ADDRESS



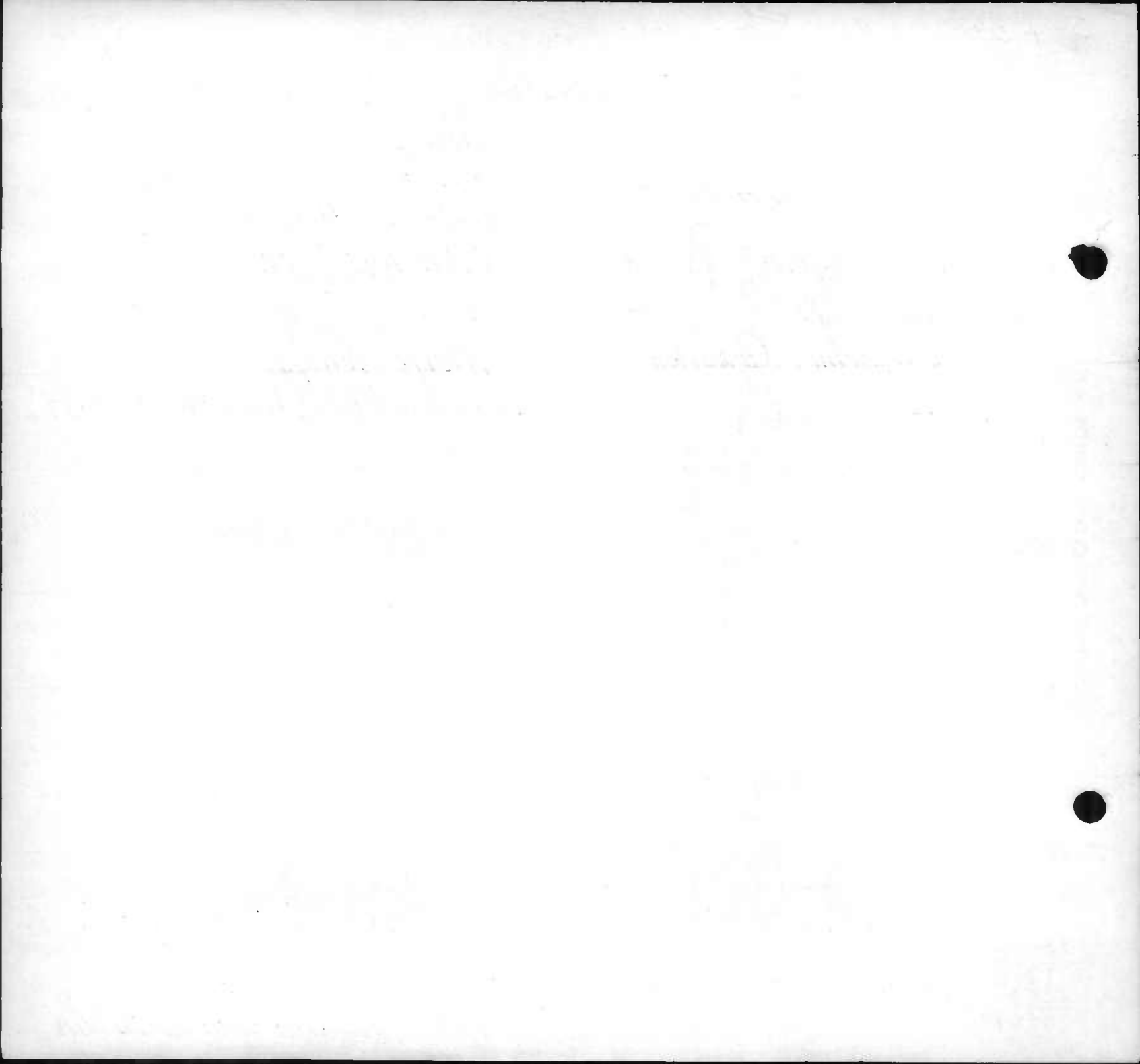
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 68- 3984 CERTIFICATE OF DEATH

REG. NO. 68- 3984

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Emma W Slaughter</i>		2. DATE AND HOUR OF DEATH <i>April 8 1968</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>1338 W 41st St.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1338 W 41st St</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 15 1895</i>	9. AGE (In years last birthday) <i>72</i>	10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>Wilhelm Grollen</i>		14. MOTHER'S MAIDEN NAME <i>Marie Knight</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no of unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>219102481</i>		17. INFORMANT <i>Lillian J. Walston</i>		ADDRESS <i>1338 W 41st St</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Occlusion</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>Aug. 1965</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 10</i> 19 <i>60</i> to <i>April 8</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>April 8</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leonard Wallerstein</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Leonard Wallerstein, M.D.</i>		23D. ADDRESS <i>848 W 36th St BAC 1111</i>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-11-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>By Norma 1007 W 41st St</i>		25D. ADDRESS <i>By Norma 1007 W 41st St</i>		25E. ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3985

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH C. THATER

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(If not in hospital or institution, give street  
address or location)

00 411 S. Clinton Street

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 11, 1968

2:39 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 25, 1906

10. AGE (In years  
lost birthday)

62

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

411 S. Clinton Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Thater

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machinist

14B. KIND OF BUSINESS OR INDUSTRY

Sewing Machine

15. MOTHER'S MAIDEN NAME

Laura E. Downey

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Santa Thater 411 S. Clinton Street

19. 412.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Hypertensive and arteriosclerotic  
cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 11, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-13-1968

24C. NAME of CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.

Special Agent in Charge  
Federal Bureau of Investigation

WIT

U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

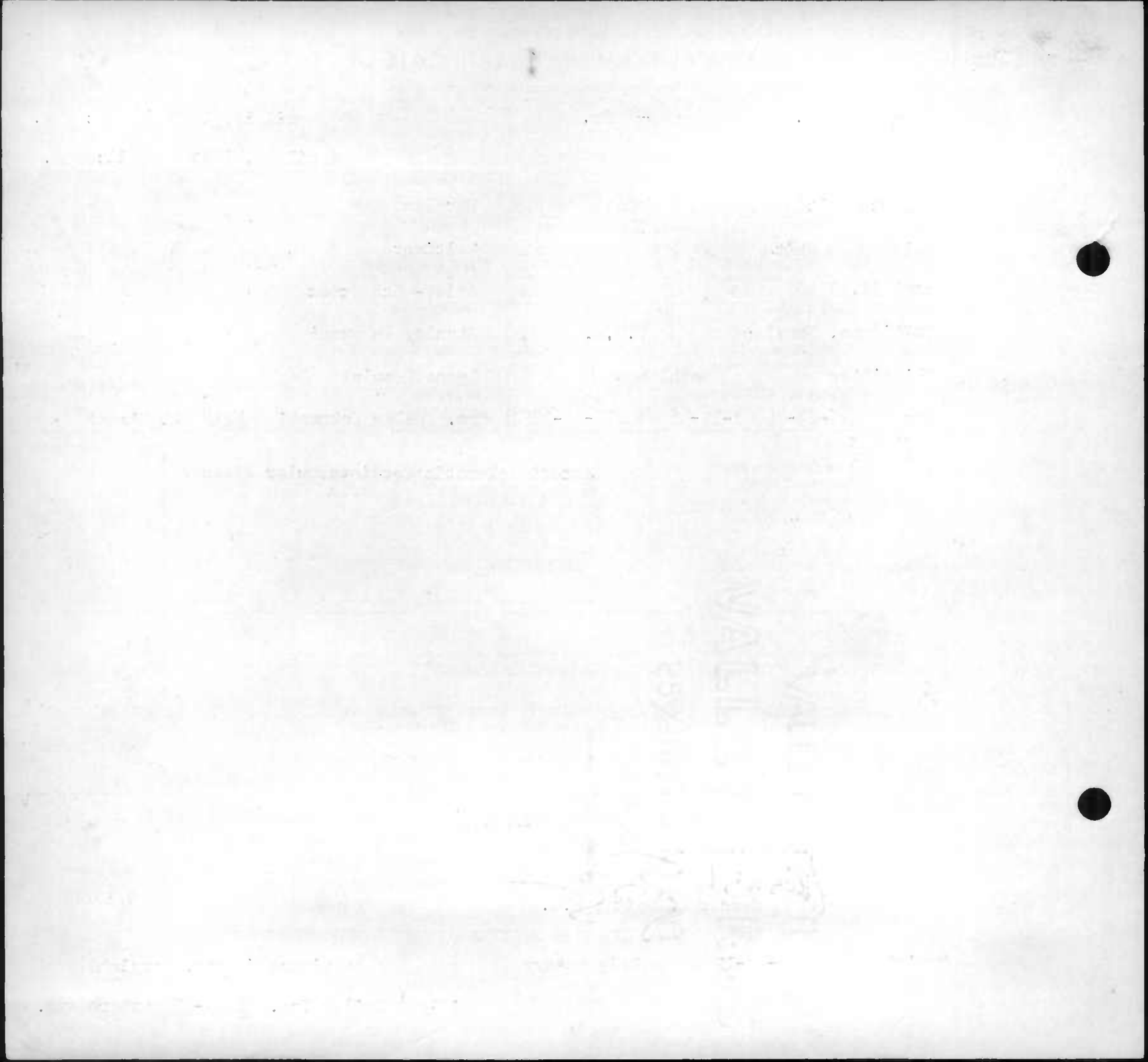
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 3986

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEO C. ZUKOWSKI Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>April 12, 1968</b> Hour <b>10:30 P.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General (DOA)</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>April 12, 1968</b> <b>11:59 A.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>25-04</b>	
9. DATE OF BIRTH <b>March 31, 1920</b>		10. AGE (In years lost birthday) <b>48</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipfitter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5-23-44 1-17-46</b>		17. SOCIAL SECURITY NO. <b>215-01-3251</b>	
13. FATHER'S NAME <b>Stanley Zukowski</b>		15. MOTHER'S MAIDEN NAME <b>Leona Pozniak</b>	
18. INFORMANT <b>Mrs. Evelyn Zukowski</b>		ADDRESS <b>4214 6th Street</b>	
19. <b>412.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>7-22-61</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>Yes</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/13/68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-1968</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 13 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	



H-325

68-3987 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-3987

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)  
COLIE

HUTSON

2. DATE  
OF  
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 9, 1968

3:35 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

B. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

6-10-1894

10. AGE (In years  
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

400 W. Myrtle Avenue

11. BIRTHPLACE (State or foreign country)

ACCOMAC CO., VIRGINIA

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

UNK.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL SECURITY NO.

218-10-2422A

18. INFORMANT

ADDRESS

Mrs. Elizabeth Savage 3009 Garrison

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Smoke and Soot Inhalation Incidental To

(A) IMMEDIATE CAUSE

~~XXXXXXXXXXXXXXXXXXXX~~ Conflagration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic Cardiovascular Disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

400 W. Myrtle Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

UNK

UNK

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

UNK

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/9/68

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-16-68

24C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 15 1968

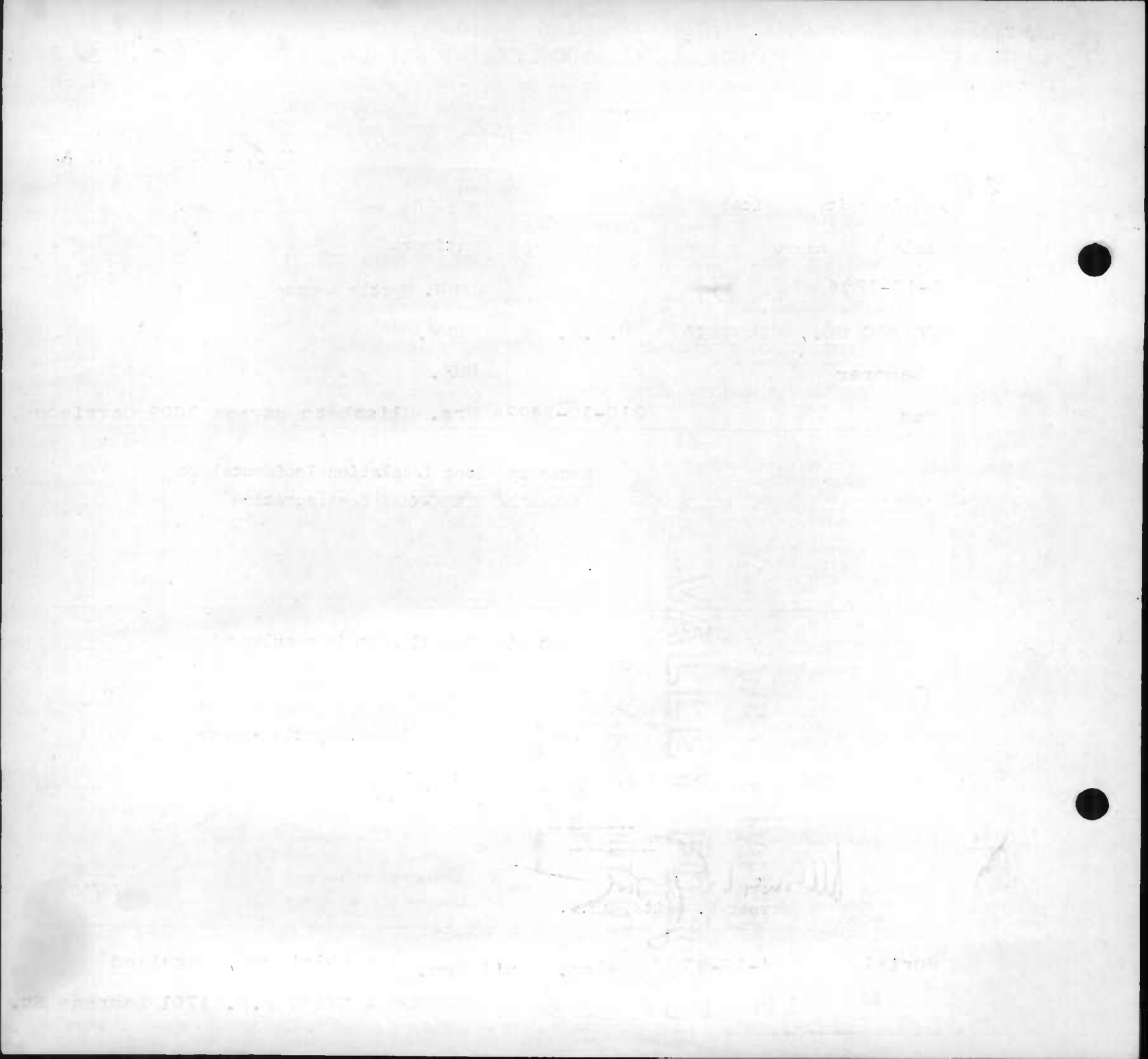
25B. NAME OF REGISTRAR

Robert E. Fairbanks

25C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT F.H. 1701 Laurens St.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3988

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

REG. NO. 68- 3988

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**WILLIAM FRED HOLT (Frederick) April 6, 1968**

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

**603 N. Bentalou Street**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

**Maryland**

C. CITY OR TOWN

**Baltimore**

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

**603 N. Bentalou Street**

5. SEX

**Male**

6. RACE

**Negro**

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

**7-27-1910**

9. AGE (In years  
last birthday)

**57**

If Under 1 Yr.  
Months Days

If Under 24 Hrs.  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

**Construction Work**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Richmond, Virginia**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME

**CHARLES HOLT**

14. MOTHER'S MAIDEN NAME

**GEORGINANA HOLT**

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

**246--46-0078 Mrs. Laura Francis Holt**

17. INFORMANT

ADDRESS

**Same**

1B.

**492X I**

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**4 days**

**Unknown**

3-27-1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

**Chr. Congestive Heart Failure**

**3-4 mos**

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **Nov 1967** to **Apr 4 1968**,  
that (I) (we) lost saw the deceased alive on **Apr 4 1968** and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

**H. Garland Chisell**

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

**4-12-68**

23C. PHYSICIAN'S  
NAME (Type)

**H. Garland Chisell**

23D. ADDRESS

**1038 Edmondson Ave Baltimore Md**

24A. BURIAL CREMATION,  
REMOVAL (Specify)

**Burial**

24B. DATE

**4-9-68**

24C. NAME OF CEMETERY or CREMATORY

**Carver Memorial Park**

24D. LOCATION

**Laurel,**

(City, town, or county)

**Maryland**

(State)

25A. DATE REC'D BY HEALTH DEPT.

**APR 15 1968**

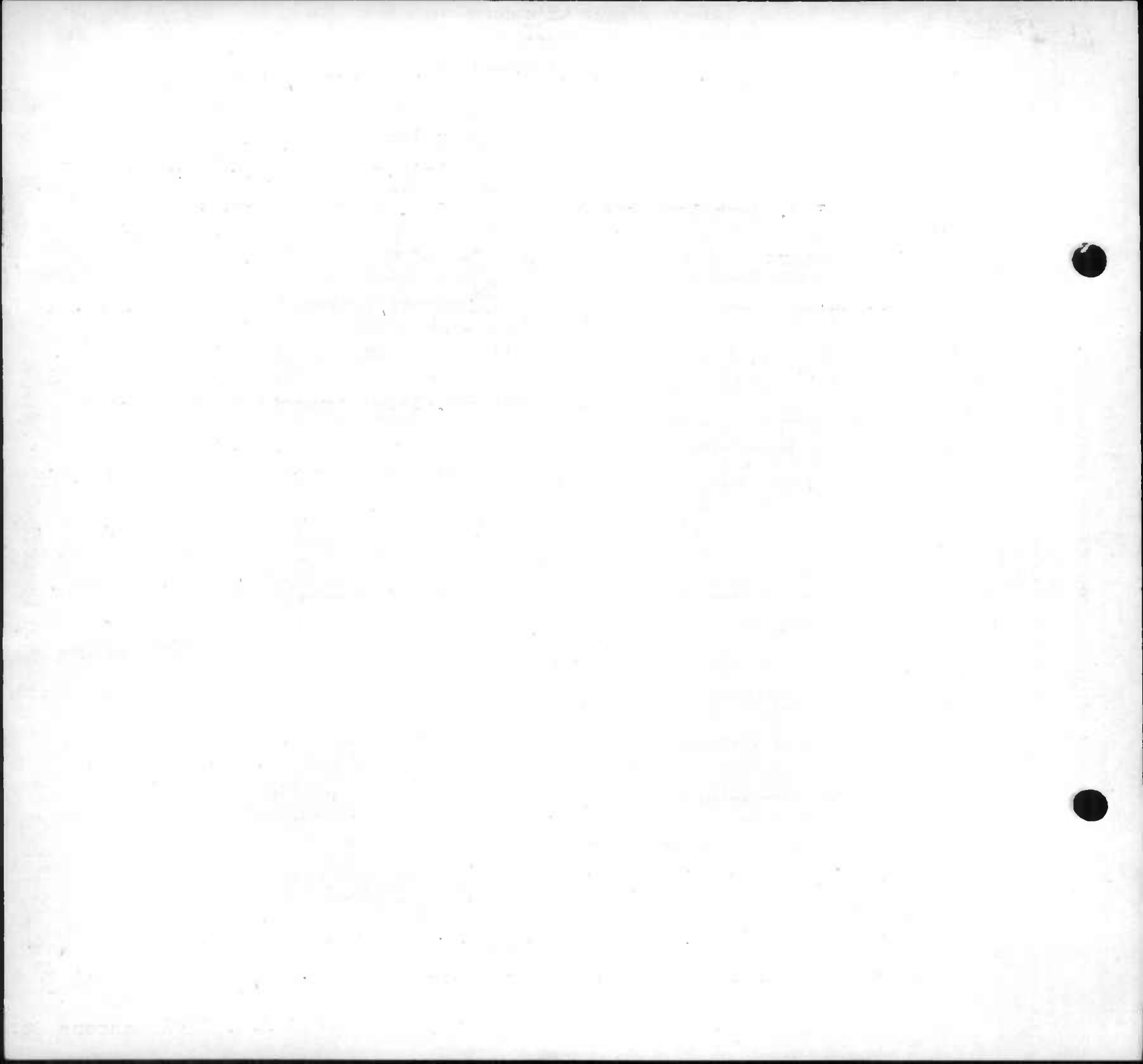
25B. NAME OF REGISTRAR

**Robert E. Taylor**

25C. FUNERAL DIRECTOR

**MORTON & DYETT F.H. 1701 Laurens St.**

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-- 3989		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-- 3989	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Johnson, Dorothy L.		4-9-68 11:55 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		Baltimore	
39 Provident Hospital 1514 Division Street Baltimore, Maryland		E. STREET AND NUMBER		1002 Vincent Street	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Negro		5-3-1900	67	Unemployed
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Virginia		U. S. A.		UNK	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
UNK		No.		17. INFORMANT ADDRESS	
Mr. Casper Whitaker		1008 Vincent		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebrovascular accident			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
331X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 3-13-68 19 to 4-9-68 19, that (I) (we) lost saw the deceased alive on 4-9-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				4-9-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
James				Provident Hospital - 1514 Division St. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	4-15-68	Mt. Auburn Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 15 1968		Robert E. Jackson		Morton E. Dyett F.H. 1701 Laurens St	

RECEIVED - NATIONAL ARCHIVES

1944

1944

Mr. C. J. ...

1944

1944

1944

H-452

68-3990

BALTIMORE CITY HEALTH DEPARTMENT

68-3990

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HOWARD (LEGUSTA) HOLMES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>April 11, 1968</b> Hour <b>6:03 P.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>624 Smathson Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>April 11, 1968</b> Hour <b>6:03 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
9. DATE OF BIRTH <b>10-11-1925</b>		10. AGE (in years lost birthday) <b>42</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>LENA HOLMES</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213-20-5803</b>	
18. INFORMANT <b>Mrs. Elizabeth DeMinds</b>		ADDRESS <b>608 W. Lanvale</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4-12-68</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-68</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Ronald N. Kornblum</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens st.</b>	

WALL 115 V. FOLIO 1011

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3991

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3991

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Ethel Thompson</b>		2. DATE AND HOUR OF DEATH <b>April 12, 1968 3:25 a. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital 1514 Division St. Baltimore, Maryland 21217</b>		E. STREET AND NUMBER <b>1723 Baker St.</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-95</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania, Phila</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Lloyd Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Unk.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Flora Thompson</b> ADDRESS <b>1723 Baker St.</b>	
18. <b>25-0.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Cadio-Respiratory arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetic coma</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus</i> (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>260X II</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1968</b> 19 to <b>April 12, 1968</b> 19, that (I) (we) last saw the deceased alive on <b>April 12, 1968</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Humberto W. Certeza M.D.</i>		DEGREE		23B. DATE SIGNED <b>April 12, 1968</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. Certeza, M. D.</b>		23D. ADDRESS <b>1514 Division St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-16-68</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F.H.</b> ADDRESS <b>1701 Laurens St.</b>	

Back-Propagating  
Back-Propagating  
Back-Propagating

Back-Propagating

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3992

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3992

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS HENDERSON

2. DATE AND HOUR OF DEATH

4/10/68

5 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL  
601 NORTH BROADWAY  
BALTIMORE, MARYLAND 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE CITY

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

948 NORTH DURHAM STREET

5. SEX

MALE

6. RACE

NEGROID

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2/02/93

9. AGE (In years last birthday)

75 YRS

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218 03 5347

17. INFORMANT

Helen Loh 948 N. Durham St

ADDRESS

18. 15570 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

METASTATIC CARCINOMA

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

? HEPATOMA (PRIMARY)

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

ASCVD CHF

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/10 1968 to 4/10 1968, that (I) (we) last saw the deceased alive on 4/10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Harry K. Genant

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/10/68

23C. PHYSICIAN'S NAME (Type)

DR. HARRY K. GENANT, M.D.

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial April 16/68

Mt. Calvary Cem

Ad County Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 15 1968

Milton E. Elckson 1129 N. Central



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-3993</u>
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WILLIE MAE SCOTT		4/11/68 12:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				
THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY, BALTO., MD. 21205				
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY		
MARYLAND CITY OF BALTIMORE				
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER		1309 WILCOX STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-10-16	51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				Henderson N.C.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
HAMP JONES		IDA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
				Willie Scott 1309 Wilcox St
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  PNEUMONIA, ENTIRE RIGHT LUNG  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  UNKNOWN				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/11/</u> 19 <u>68</u> to <u>4/11</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/11/</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>John R. Stone</u>				23B. DATE SIGNED <u>4/11/68</u>
23C. PHYSICIAN'S NAME (Type) <u>JOHN R. STONE, MD</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
<u>Burial</u>		<u>April 16/68</u>		<u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS		
<u>Westport Md</u>		<u>Milton E. Elchman 1127 N. Court St</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor</u>		25C. FUNERAL DIRECTOR ADDRESS

10

68-3994

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-3994

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

COLLINS BERRY

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

April 6, 1968

9:40 A.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

April 25, 1914

10. AGE (In years  
lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1236 E. Monument Street

11. BIRTHPLACE (State or foreign country)

Unemployed SC

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Berry

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lelia Lund

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Daisy Gillard - 2005 N. W. 46 St

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Hypertensive cardiovascular disease  
with marked nephrosclerosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).Pulmonary emphysema with extensive  
pulmonary fibrosis

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 7, 1968

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Page 100

WALLIE 2-11-47

23/9/46

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-3995	
BIRTH NO. 68-3995				1. NAME OF DECEASED (Type or Print) <b>Lacy GRAHAM</b>		2. DATE AND HOUR OF DEATH <b>2:30 AM 4-13-68</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1522 E Chase ST.</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-06</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.C.</b>			
13. FATHER'S NAME <b>WILLIE GRAHAM</b>				14. MOTHER'S MAIDEN NAME <b>ISABELLE ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mozell Graham</b>		ADDRESS	
18. <b>4-10-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>420.1 II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>10 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-26</b> 19 <b>68</b> to <b>4-13</b> 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4-12</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John V. Russo M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-13-68</b>	
23C. PHYSICIAN'S NAME (Type) <b>John V. Russo M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 17/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Frank P. Elicker</b>		ADDRESS <b>1129 N. Carroll Ave</b>	

10-14-00

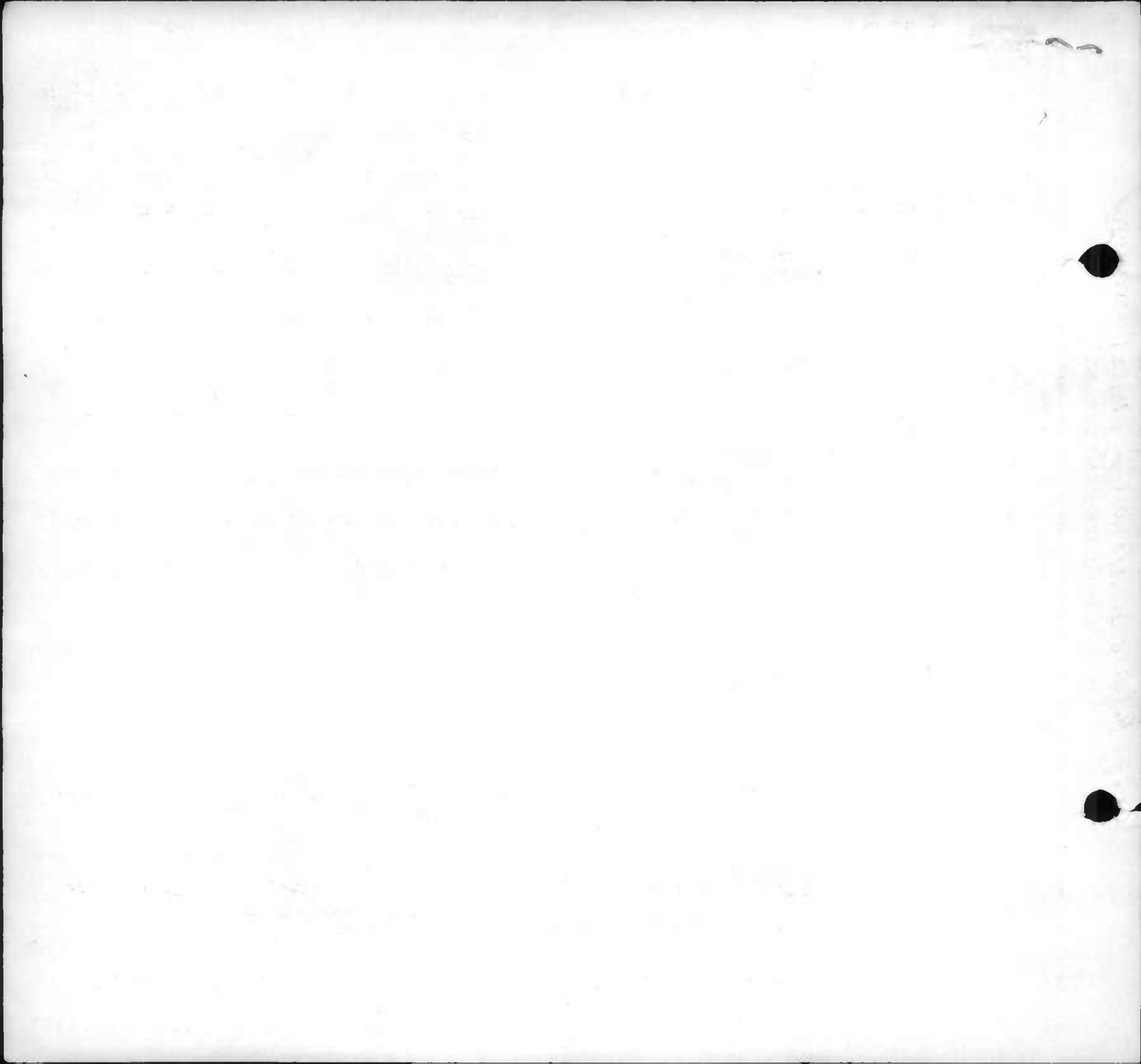
W m

*[Faint, illegible handwriting]*

Release on approval by Medical Examiner.  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-355		68- 3996		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 3996	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
GOODMAN, MAX				April 10, 1968 12:20 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
SINAI HOSPITAL OF BALTIMORE				MD			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				4030 PARK HEIGHTS AVE. #15			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	9-5-1910	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
REF.		SERVICE		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DANIEL GOODMAN				KATIE GOLD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		215-07-9384		MRS. JEANETTE GOODMAN,		4030 PARK HEIGHTS AVENUE, BALTO.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				INTERVAL BETWEEN ONSET AND DEATH			
410.9 I				(A) ACUTE MYOCARDIAL INFARCTION 25 min.			
2288 APPROVED BY [Signature]				(B) ISCHAEMIC HEART DISEASE 3 years			
				(C) ATHEROSCLOSIS over 6 years			
420.1 II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
April 10		myocardial re-vascularization					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 7 1968 to April 10 1968, that (I) (we) last saw the deceased alive on April 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
[Signature] MB.BS. M.D.				April 10, 1968			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
S. K. CHUNG MB.BS. M.D.				Sinai Hospital of Baltimore, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		4-11-68		LIBERTY PARK		RANDALLSTOWN, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 15 1968		[Signature]		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN ROAD., BALTO. 21215	



FUNERAL DIRECTOR: IMPORTANT

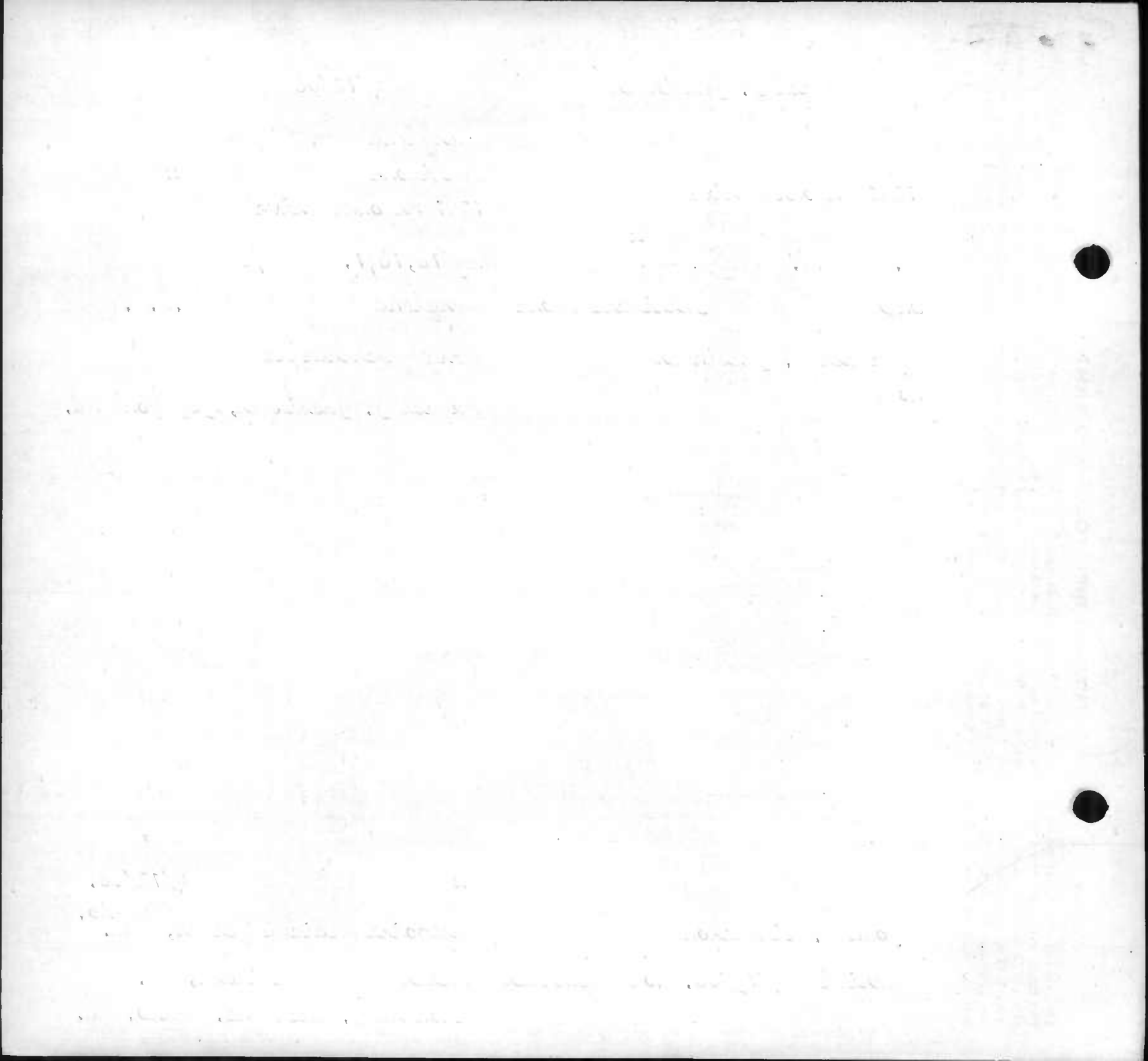
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 3997

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 3997

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>August J. Gassinger</i>		2. DATE AND HOUR OF DEATH <i>4/11/68</i> <i>7<sup>00</sup> P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1201 Argonne Drive</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER <i>1201 Argonne Drive</i>	
5. SEX <i>M.</i>	6. RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 18, 1891.</i>	9. AGE (In years last birthday) <i>76</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Furniture Store</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>August A. Gassinger</i>			14. MOTHER'S MAIDEN NAME <i>Mary Schendelle</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>August G. Gassinger, 6505 York Rd.</i>	
18. <i>4/12/68</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>722.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Accident</i> (B) <i>Atherosclerotic Cardiovascular Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Aug 12</i> <i>1965</i> to <i>April 11</i> <i>1968</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>Jan 18</i> <i>1968</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>John B. Littleton M.D.</i> DEGREE				23B. DATE SIGNED <i>4/12/68.</i>	
23C. PHYSICIAN'S NAME (Type) <i>John B. Littleton</i> DEGREE				23D. ADDRESS <i>Eastpoint Medical Center, Balto. Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/15/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Fulkerson</i>	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

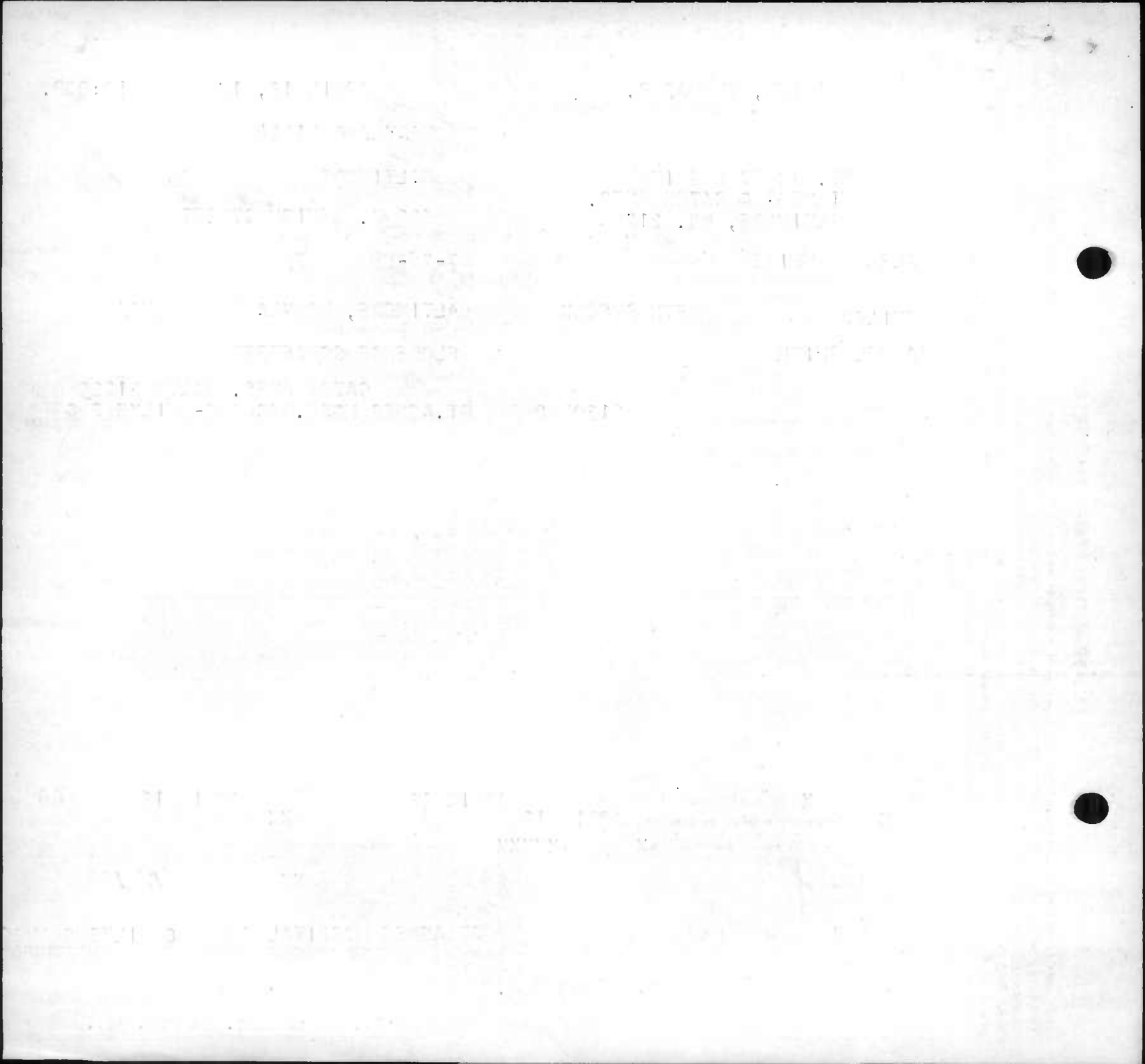
68- 3998

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

68- 3998

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SMITH, THOMAS P.		APRIL 13, 1968   10:00P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND. 21224	
40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 522 S. LEHIGH STREET	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-28-88	79	RETIRE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
		BETH STEELM	BALTIMORE, MARYLAND	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
SAMUEL SMITH			FLORENCE SCHAEFFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		213079085	CATON AVES. BALTO 21229 ST. AGNES HOSP. RECORDS- WILKENS &		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetic Acidosis</i>					
(B) <i>Broncho pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <i>Septicemia</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from APRIL 13 19 68 to APRIL 13 19 68, that (X) (we) last saw the deceased alive on APRIL 13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>John J. Ruck</i>				04/14/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Pollock, Fred				ST AGNES HOSPITAL CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/17/68		Mt. Olivet Cem.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 15 1968		Robert E. Taylor		Leonard J. Ruck Inc. Balto. Md.	



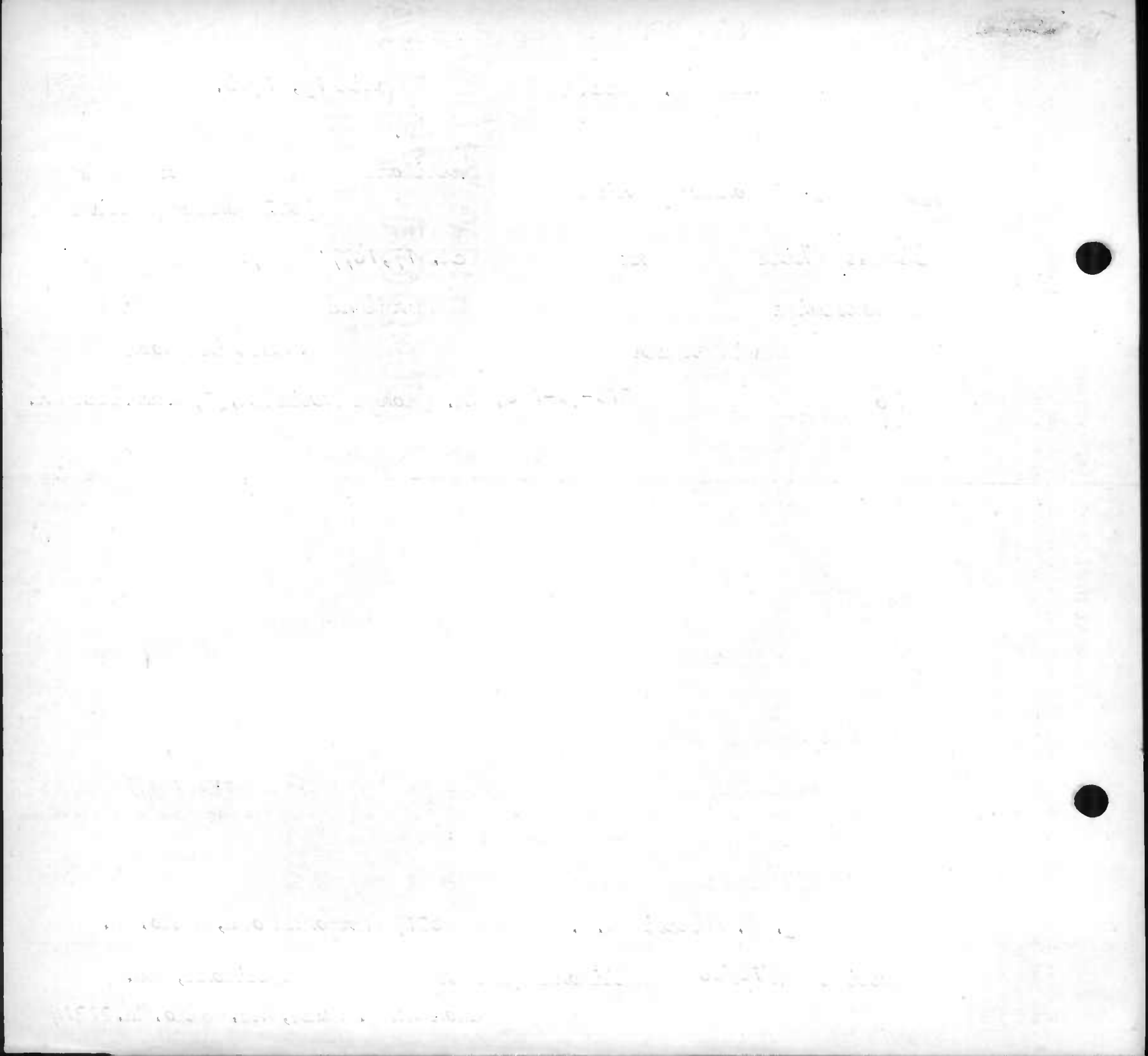
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
68- 3999 CERTIFICATE OF DEATH

REG. NO. 68- 3999

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anna M. Beck</i>		2. DATE AND HOUR OF DEATH <i>April 13, 1968. 11:55 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 3002 Northway Drive</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3002 Northway Drive</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1877</i>	9. AGE (In years last birthday) <i>90</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>David Brauer</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Hook</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-1089</i>		17. INFORMANT ADDRESS <i>Mr. George Stricker, 927 Dunellen Dr.</i>	
18. <i>412.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic Heart Disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>420.0 II</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>Feb 10</i> 19 <i>68</i> to <i>April 13</i> 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>April 13</i> 19 <i>68</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <i>E. J. Alessi</i>		DEGREE <i>MD</i>		23B. DATE SIGNED <i>4/13/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. J. Alessi M.D.</i>		23D. ADDRESS <i>6217 Harford Road, Balto. Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/16/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 4000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 68- 4000

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Gaskins, Mrs. Chloe W.</b>		2. DATE AND HOUR OF DEATH <b>4-13-68</b> <b>1:45 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick Home for Incurables of Baltimore City</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Charles Apartments</b>		12-02	
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-84</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Northumberland, Va.</b>	
13. FATHER'S NAME <b>James B. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Tebodo Edwards</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-10-1986</b>		17. INFORMANT <b>Mary B. DiPaula, R.N.</b>	
				ADDRESS <b>Keswick</b>	
18. <b>4/12/68</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>may yrs terminal episode (rule)</b>	
19A. DATE OF OPERATION <b>4/22/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diabetes mellitus</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 62</b> to <b>13 April 19 68</b> , that (I) (we) last saw the deceased alive on <b>13 April 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Biehl</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/13/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Harold P. Biehl</b> <b>Aubrey D. Richardson, M.D.</b>		23D. ADDRESS <b>700 W. 40th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/16/68</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 15 1968</b>			
25B. NAME OF REGISTRAR <b>Robert E. Finkbeiner</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md.</b>		ADDRESS <b>21214</b>	

